Aging and Disability Services Division
Provider Services Application
Community Options program for the Elderly (COPE) & Elder Rights

All questions must be completed by ***all providers*** *unless otherwise marked.* ***Attach additional sheets*** *if necessary to answer each question completely. Each additional sheet must display the* ***relevant question number*** *from the Application and must be* ***signed by the provider*** *or authorized representative.*

Application Type *(Circle one)*: ***New*** ***Renewal/Adding*** *services to an existing agreement* ***Ownership Change*** *(fill out new vendor registration with the* Nevada State Controller's Office *and contact Aging & Disability Services for additional "Assignment of Provider Amendment" form*

Indicate below which services you are enrolling to provide for:
Community Options program for the Elderly (COPE) & Elder Rights

Title XX Homemaker Program

☐ Homemaker

Community Options Program for the Elderly (COPE)

☐ Attendant ☐ Homemaker ☐ Adult Day Care ☐ Companion ☐ Chore

☐ Respite ☐ Personal Emergency Response System (PERS)

Personal Assistance Program (PAS)

☐ Standard, non-medical personal care services

☐ Personal care services as an Intermediary Service Organization (ISO), this includes all skilled services and those where the Recipient chooses to manage their own services.

Elder Rights

☐ EPS Homemaker ☐ Mental Health Evaluations

☐ Temporary Assistance to Displaced Seniors (TADS)

Section 1: General Information

1. Business owner (or individual provider) Name:
2. Provider Date of Birth *(for individual providers only)*:
3. Tax Identifier *(Federal Tax ID Number-last four digits only)*:
4. Check the box that most closely describes the entity you are enrolling:

   ☐ Individual Provider ☐ Hospital-based Physician ☐ Provider Group ☐ Sole Proprietorship

   ☐ Partnership ☐ Limited Liability Partner ☐ Limited Liability Company ☐ Corporation

   ☐ Managed Care Organization ☐ Non-Profit ☐ Indian Health Services
5. Legal Name as Registered with the Internal Revenue Service (IRS):
6. Doing Business As:
7. Nevada Secretary of State Registered Name:

8. Nevada Secretary of State Issued Business ID :

9. Medicare Provider Number, if applicable:

10. Physical location of the practice/business/facility. This must be a street address and NOT a post office box.

Address (Line 1):

Address (City, State, Zip and COUNTY):

Office Phone: Extension: E-mail Address:

Fax: TTY Phone:

Mailing Address if different from physical:

Address (Line 1):

Address (City, State, Zip and County):

11. Enter the following information for your professional license (s) that pertains to the service(s) you wish to provide.

Professional License Number:

Name of Issuing Licensing Board, State or Entity:

Professional License Number:

Name of Issuing Licensing Board, State or Entity:

Professional License Number:

Name of Issuing Licensing Board, State or Entity:

Section 2: Background Information and Disclosure

12. Have you or any owner, administrator, manager or employee ever been convicted of a misdemeanor, gross misdemeanor or felony? ☐ Yes ☐ No If yes, provide the following information for each conviction.

Name Used When Convicted: Date of Conviction:

Charges: Disposition:

Conditions of Parole/Probation:

Have you or any owner, administrator, manager or employee ever been placed on the Federal Office of Inspector General, Health and Human Service (OIG/HHS) exclusion list or otherwise been suspended or debarred from participation in Medicare, Medicaid, Title XVIII or Title XIX programs since the inception of these programs?

If yes, provide the following information related to the sanction.

Name Used When Sanctioned:

Provider ID Number(s): Group ID Number(s):

Sanction Effective Date: Reinstatement Date:

13. If you or any owner, administrator, manager or employee has had any professional, business or accreditation license/certificate denied, suspended, restricted or revoked, complete the following for each instance.

Denial/Suspension/Restriction/Revocation From and To Dates:

Explanation:

14. Are you or any owner, administrator, manager or employee a state employee *(past or current)*? If yes, complete the following:

Individual's Name:

Agency of Employment: Title:

Dates of Employment:

Declaration – For All Providers

I declare under penalty of perjury under the laws of the State of Nevada that the information in **this document and any attachments are true, accurate and complete** to the best of my knowledge and belief. I declare that I have the authority to legally bind the provider(s) listed on this Application. I understand that Aging and Disability Services Division (ADSD) will rely on this information in entering into or continuing a Service Provider Agreement and that this form will be incorporated into and become a part of my ADSD Service Provider Agreement.

I understand that I am required to **notify ADSD within five days** of changes to information on this Application. I understand that **I am responsible for the presentation of true, accurate and complete information on all invoices/claims** submitted. I further understand that payment and satisfaction of these claims will be from Federal and State funds and that false claims, statements, documents or concealment of material facts may be prosecuted under applicable Federal and State laws.

Use dark blue or black ink only. This Application and corresponding contract must be dated within the last 60 days. The person signing below is the *(check all that apply)*: ☐ Provider ☐ Authorized Administrator ☐ Business Owner

Signature: Date:

Print Name:

Return completed agreement to Aging and Disability Services Division located at:

3416 Goni Road, D-132
Carson City, Nevada 89706
Phone: 775-687-4210

Internal Use Only: Status of Approval

Title XX Homemaker Program

Homemaker ☐ Yes ☐ No

Community Options Program for the Elderly (COPE)

Attendant	☐ Yes	☐ No	Companion	☐ Yes	☐ No
Homemaker	☐ Yes	☐ No	Chore	☐ Yes	☐ No
Adult Day Care	☐ Yes	☐ No	Respite	☐ Yes	☐ No

Personal Emergency Response System (PERS) ☐ Yes ☐ No

Personal Assistance Program (PAS)

Standard, non-medical personal care services ☐ Yes ☐ No

Intermediary Service Organization (ISO) services ☐ Yes ☐ No

Elder Rights

EPS Homemaker ☐ Yes ☐ No Mental Health Evaluations ☐ Yes ☐ No

Temporary Assistance to Displaced Seniors (TADS) ☐ Yes ☐ No

Master Services Provider Agreement
State of Nevada
Department of Health and Human Services
Aging and Disability Services Division

This Agreement between State of Nevada, Department of Health and Human Services, Aging and Disability Services Division, (hereinafter called State or Division or Program) and the undersigned Provider or Provider Group and its members (hereinafter called Provider) is dated as set forth below and is made pursuant to Nevada Revised Statutes, Chapter 427A, there under to provide appropriate and timely services authorized for reimbursement (hereinafter called "Services") to eligible Division Recipients (hereinafter Recipients). On its effective date, this Provider Agreement supersedes and replaces any existing contracts between the parties related to the provision of Services to Recipients. The Nevada Aging and Disability Services Division, is authorized to obtain, and the Provider is ready, willing and able to provide, such services. Therefore, in consideration of the mutual promises and other valuable consideration exchanged by the parties hereto:

I. Provider Agrees:

1. To adhere to standards of practice, professional standards and levels of Service as set forth in all applicable local, state and federal laws, statutes, rules and regulations as well as administrative policies and procedures set forth by the Division relating to the Provider's performance under this Agreement.

2. To operate and provide Services to Recipients without regard to age, sex, race, color, religion, national origin, disability or type of illness or condition. This includes providing Services in accordance with the terms of Section 504 of the Rehabilitation Act of 1973, (29 U.S.C. § 794). To provide services in accordance with the terms, conditions and requirements of Americans with Disabilities Act of 1990 (P.L. 101-336), 42 U.S.C. 12101, and regulations adopted hereunder contained in 28 C.F.R. §§ 36.101 through 36.999, inclusive.

3. To provide Services in accordance with the terms, conditions and requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and regulations adopted there under contained in 45 CFR 160, 162 and 164.

4. To obtain and maintain all licenses, permits, certification, registration and authority necessary to do business and render service under this Agreement. Where applicable, the provider shall comply with all laws regarding safety, unemployment insurance and workers compensation. Copies of applicable licensure/certification must be submitted at the time of each license/certification renewal.

5. To check the List of Excluded Individuals/Entities on the Office of Inspector General (OIG) website prior to hiring or contracting with individuals or entities and periodically check the OIG website to determine the participation/exclusion status of current employees and contractors.

Provider Agreement Form Prior Approved
By the State Board of Examiners on 7/13/2012

6. To obtain prior authorizations, submit accurate, complete and timely claims, and conduct business in such a way the Recipient retains freedom of choice of provider.

7. To exhaust all Administrative remedies prior to initiating any litigation against the Division.

8. To adhere to standards of practice, professional standards and levels of Service as set forth in all applicable local, state and federal laws, statutes, rules and regulations as well as any applicable administrative policies and procedures set forth by the Division relating to the Provider's provision of Services. All relevant Program statutes, regulations, administrative policies and procedures constitute the "Program" and are hereby incorporated into this Agreement as Scope of Work(s). Any changes to the Program during the term of this Agreement shall automatically be incorporated into this Agreement.

9. To provide for adequate insurance coverage for any business liability and/or professional acts or omissions pursuant to this Agreement. To the fullest extent permitted by law, provider shall indemnify, hold harmless and defend, not excluding the State's right to participate, the State from and against all liability, claims, actions, damages, losses, and expense, including, without limitation, reasonable attorneys' fees and cost, arising out of any alleged negligent or willful acts or omissions of Provider, its officers, employees and agents.

10. That by signing this Agreement, Provider certifies that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency. This certification is made pursuant to regulations implementing Executive Order 12549, Debarment and Suspension, 28 C.F.R. pt. 67 § 67.510, as published as pt. VII of May 26, 1988, Federal Register (pp.19150-19211). This provision shall be required of every subcontractor receiving any payment in whole or in part from federal funds.

11. That the Provider's books, records (written, electronic, computer related or otherwise), including, without limitation, relevant accounting procedures and practices of Provider or its subcontractors, financial statements and supporting documentation, and documentation related to the Services and reimbursement claims under this Agreement shall be subject, at any reasonable time, to inspection, examination, review, audit, and copying at any office or location of Provider where such records may be found, with or without notice by the Division or its designee. All subcontracts shall reflect requirements of this paragraph.

12. That the Provider is associated with the State only for the purposes and to the extent specified in this Agreement, and in respect to performance of the agreed services pursuant to this Agreement, Provider is and shall be an independent contractor and, subject only to the terms of this Agreement, shall have the sole right to supervise, manage, operate, control, and direct performance of the details incident to its duties under this Agreement. Nothing contained in this Agreement shall be deemed or construed to create a partnership or joint venture, to create relationships of an employer-employee or principal-agent, or to otherwise create any liability for the State whatsoever with respect to the indebtedness, liabilities, and obligations of Provider or any other party. Provider shall be solely responsible for, and the State shall have no obligation with respect to: (1) withholding of income taxes, FICA or any other taxes or fees; (2) industrial insurance coverage; (3) participation in any group insurance plans available to

employees of the State; (4) participation or contributions by either Provider or the State to the Public Employees Retirement System; (5) accumulation of vacation leave or sick leave; or (6) unemployment compensation coverage provided by the State. Provider shall indemnify and hold State harmless from, and defend State against, any and all losses, damages, claims, costs, penalties, liabilities, and expenses arising or incurred because of, incident to, or otherwise with respect to any such taxes or fees.

13. Provider will perform functions and/or activities that involve the use and disclosure of Protected Health Information in the provision of, or in claims for reimbursement for, Services as authorized by the Program; therefore, the Provider will be considered a HIPAA Business Associate of the Division unless Provider falls within an exception recognized by the federal Office of Civil Rights (HIPAA Privacy). It will be the responsibility of the Provider to fully document in writing to the Division the facts supporting any request to be recognized by the Division as being exempt from the execution of the Division's additional HIPAA Business Associate Agreement (which upon execution shall be incorporated into this Agreement).

14. No Services may be provided to a Recipient, nor reimbursement claimed, prior to Provider's (and any of the Provider's applicable subcontractors') separate execution and delivery of the Division's HIPAA Business Associate Agreement or otherwise receipt of the Division's concurrence in writing that Provider's (or applicable subcontractor's) Services fall within an exception from the HIPAA business associate requirements. Provider will have a duty to disclose to the Division any of its subcontractors that are providing business associate functions or activities (having access to Protected Health Information) including without limitation: claims processing or administration, data analysis, utilization review, quality assurance, billing, benefit management, practice management, re-pricing, legal services, accounting services, consulting services, data aggregation, and office management.

II. Both Parties Agree:

1. That this Agreement may be terminated as follows:
   a. Termination without Cause. Any discretionary or vested right of renewal notwithstanding, this Agreement may be terminated upon written 30-day notice by mutual consent of both parties or unilaterally by either party without cause.
   b. State Termination for Nonappropriation. The continuation of this provider agreement beyond the current biennium is subject to and contingent upon sufficient funds being appropriated, budgeted, and otherwise made available by the State Legislature and/or federal sources. The State may terminate this agreement, and the provider waives any and all claim(s) for damages, effective immediately upon receipt of written notice (or any date specified therein) if for any reason the Provider's funding from State and/or federal sources is not appropriated or is withdrawn, limited, or impaired.
   c. Cause Termination for Default or Breach. A default or breach may be declared with or without termination. This Agreement may be terminated by either party upon 30-day written notice of default or breach to the other party.
   d. Winding up Affairs upon Termination. In the event of termination of this Agreement for any reason, the parties agree that the provisions of this paragraph survive termination:

i. The parties shall account for and properly present to each other all claims for fees and expenses and pay those, which are undisputed and otherwise not subject to set-off under this Agreement or the Program;
ii. Provider shall preserve, protect and promptly deliver into State possession all proprietary information owned by the State, if any.

2. The State will not waive and intends to assert available NRS chapter 41 liability limitations in all cases. Agreement liability of both parties shall not be subject to punitive damages. Damages for any State breach shall never exceed the amount of outstanding unreimbursed claims submitted pursuant to the Program.

3. Neither party shall be deemed to be in violation of this Agreement if it is prevented from performing any of its obligations hereunder due to strikes, failure of public transportation, civil or military authority, act of public enemy, accidents, fires, explosions, or acts of God, including, without limitation, earthquakes, floods, winds, or storms. In such an event the intervening cause must not be through the fault of the party asserting such an excuse, and the excused party is obligated to promptly perform in accordance with the terms of the Agreement after the intervening cause ceases.

4. This Agreement and the rights and obligations of the parties hereto shall be governed by, and construed according to, the laws of the State of Nevada, without giving effect to any principle of conflict-of-interest that would require the application of the law of any other jurisdiction. Provider consents to the jurisdiction of the Nevada district courts for enforcement of this Agreement.

5. This Agreement and its integrated attachment(s) constitute the entire agreement of the parties and such are intended as a complete and exclusive statement of the promises, representations, negotiations, discussions, and other agreements that may have been made in connection with the subject matter hereof. Unless an integrated attachment to this Agreement specifically displays a mutual intent to amend a particular part of this Agreement, general conflicts in language between any such attachment and this Agreement shall be construed as consistent with the terms of this Agreement. Unless otherwise expressly authorized by the terms of this Agreement, no modification or amendment to this Agreement shall be binding upon the parties unless the same is in writing and signed by the respective parties hereto and approved by the Office of the Attorney General and the State Board of Examiners.

III. Reimbursement:

1. The Program will provide reimbursement payment for authorized and timely claimed Services provided to qualified Recipients by the enrolled Provider, for any such Services actually and properly rendered by the Provider in accordance with Program statutes, regulations, administrative policies and procedures. The Program's reimbursement rates may vary over the term of this Agreement and must conform to the established reimbursement rates in force with respect to the Program's receipt of each Provider claim.

2. The Provider is responsible for the validity and accuracy of claims whether submitted on paper, electronically or through a billing service.

3. The Provider agrees to pursue the Recipient's other medical insurance and resources prior to submitting a claim for Service to the Division's Fiscal Agent. This includes but is not limited to Medicare, private insurance, Recipient co-payments, medical benefits provided by employers and unions, worker compensation and any other third party insurance.

4. The Provider shall accept payment from the Division as payment in full on behalf of the Recipient, and agrees not to bill, retain or accept payments for any additional amounts except as provided for in item number 3 above. The Provider shall immediately repay the Division in full for any claims where the Provider received payment from another party after being paid by the Division.

5. Provider agrees excess payments beyond authorized reimbursement to a Provider may be deducted from future Program payments at the discretion of the Program.

6. Provider agrees to be responsible for federal or state sanctions or remedies including but not limited to reimbursement, withholding, recovery, suspension, termination or exclusion on any claims submitted or payments received. Any false claims, statements or documents concealment or omission of any material facts may be prosecuted under applicable federal or state laws.

IV. Notices:

All notices must be in writing and shall be deemed received when delivered in person; by email; or, if sent to address on file by first-class United States mail, proper postage prepaid. Provider shall notify the Division and/or Fiscal Agent within five (5) working days of any of the following.

1. Any action which may result in the suspension, revocation, condition, limitation, qualification or other material restriction on a Provider's licenses, certifications, permits or staff privileges by any entity under which a Provider is authorized to provide Services including indictment, arrest or felony conviction or any criminal charge.

2. Change in corporate entity, servicing locations, mailing address or addition to or removal of practitioners or any other information pertinent to the receipt of Division Funds.

3. When there is a change in ownership, the terms and agreements of the original Agreement is assumed by the new owner, and the new owner shall, as a condition of participation, assume liability, jointly and severally with the prior owner for any and all amounts that may be due, or become due to the Division, and such amounts may be withheld from the payment of claims submitted when determined. Change in ownership requires full disclosure of the terms of the sale agreement.

V. Miscellaneous:

1. Both parties mutually agree that the Division Provider Enrollment Application submitted and signed by the Provider is incorporated by reference into this agreement and is a part hereof as though fully set forth herein.

2. The Division may terminate this agreement immediately when the Division receives notification that the Provider no longer meets the professional credential/licensing/insurance requirements.

VI. Term of Agreement:

This Agreement shall be in effect from _____through_____.
This Agreement will automatically renew for successive one-year terms unless terminated upon notice by either party.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be signed and intend to be legally bound thereby.

Aging and Disability Services Division	Provider Name: _____
3416 Goni Road D-132	Address: _____
Carson City NV 89706	_____
Phone: 775-687-4210	Phone: _____
Fax: 775-687-4264	Fax: _____
_____	_____
Authorized Signature	Authorized Signature
_____	_____
Print Name	Print Name
_____	_____
Print Title	Print Title
_____	_____
Date	Date

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

BUSINESS ASSOCIATE ADDENDUM BETWEEN

The Department of Health and Human Services
Herein after referred to as the "Covered Entity"

and

_____
Herein after referred to as the "Business Associate"

PURPOSE. In order to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191, and the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, Public Law 111-5 this Addendum is hereby added and made part of the Contract between the Covered Entity and the Business Associate. This Addendum establishes the obligations of the Business Associate and the Covered Entity as well as the permitted uses and disclosures by the Business Associate of protected health information it may possess by reason of the Contract. The Covered Entity and the Business Associate shall protect the privacy and provide for the security of protected health information disclosed to the Business Associate pursuant to the Contract and in compliance with HIPAA, the HITECH Act, and regulation promulgated there under by the U.S. Department of Health and Human Services ("HIPAA Regulations") and other applicable laws.

WHEREAS, the Business Associate will provide certain services to the Covered Entity, and, pursuant to such arrangement, the Business Associate is considered a business associate of the Covered Entity as defined in HIPAA Regulations; and

WHEREAS, Business Associate may have access to and/or create, receive, maintain or transmit certain protected health information from or on behalf of the Covered Entity, in fulfilling its responsibilities under such arrangement; and

WHEREAS, HIPAA Regulations require the Covered Entity to enter into a contract containing specific requirements of the Business Associate prior to the disclosure of protected health information; and

THEREFORE, in consideration of the mutual obligations below and the exchange of information pursuant to this Addendum and to protect the interests of both Parties, the Parties agree to all provisions of this Addendum.

I. DEFINITIONS. The following terms in this Addendum shall have the same meaning as those terms in the HIPAA Regulations: Breach, Data Aggregation, Designated Record Set, Disclosure, Electronic Health Record, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Subcontractor, Unsecured Protected Health Information, and Use.

1. **Business Associate** shall mean the name of the organization or entity listed above and shall have the meaning given to the term under the Privacy and Security Rule and the HITECH Act. For full definition refer to 45 CFR 160.103.
2. **Contract** shall refer to this Addendum and that particular Contract to which this Addendum is made a part.
3. **Covered Entity** shall mean the HIPAA covered components of the Department listed above (Aging & Disability Services, Child and Family Services, Division of Public and Behavioral Health, Division of Health Care Financing & Policy) and shall have the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to 45 CFR 160.103.

4. **Parties** shall mean the Business Associate and the Covered Entity.

II. OBLIGATIONS OF THE BUSINESS ASSOCIATE

1. **Access to Protected Health Information.** The Business Associate will provide, as directed by the Covered Entity or an individual, access to inspect or obtain a copy of protected health information about the individual that is maintained in a designated record set by the Business Associate or its agents or subcontractors, in order to meet the requirements of HIPAA Regulations. If the Business Associate maintains an electronic health record, the Business Associate, its agents or subcontractors shall provide such information in electronic format to enable the Covered Entity to fulfill its obligations under HIPAA Regulations.
2. **Access to Records.** The Business Associate shall make its internal practices, books and records relating to the use and disclosure of protected health information available to the Covered Entity and to the Secretary for purposes of determining Business Associate's compliance with HIPAA Regulations.
3. **Accounting of Disclosures.** Upon request, the Business Associate and its agents or subcontractors shall make available to the Covered Entity or the individual information required to provide an accounting of disclosures in accordance with HIPAA Regulations.
4. **Agents and Subcontractors.** The Business Associate must ensure all agents and subcontractors that create, receive, maintain, or transmit protected health information on behalf of the Business Associate agree in writing to the same restrictions and conditions that apply to the Business Associate with respect to such information. The Business Associate must implement and maintain sanctions against agents and subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation as outlined under HIPAA Regulations.
5. **Amendment of Protected Health Information.** The Business Associate will make available protected health information for amendment and incorporate any amendments in the designated record set maintained by the Business Associate or its agents or subcontractors, as directed by the Covered Entity or an individual, in order to meet the requirements of HIPAA Regulations.
6. **Audits, Investigations, and Enforcement. If the data provided or created through the execution of the Contract** becomes the subject of an audit, compliance review, or complaint investigation by the Office of Civil Rights or any other federal or state oversight agency, the Business Associate shall notify the Covered Entity immediately and provide the Covered Entity with a copy of any protected health information that the Business Associate provides to the Secretary or other federal or state oversight agency concurrently, to the extent that it is permitted to do so by law. The Business Associate and individuals associated with the Business Associate are solely responsible for all civil and criminal penalties assessed as a result of an audit, breach or violation of HIPAA Regulations.
7. **Breach or Other Improper Access, Use or Disclosure Reporting.** The Business Associate must report to the Covered Entity, in writing, any access, use or disclosure of protected health information not permitted by the Contract, Addendum or HIPAA Regulations by Business Associate or its agents or subcontractors. The Covered Entity must be notified immediately upon discovery or the first day such breach or suspected breach is known to the Business Associate or by exercising reasonable diligence would have been known by the Business Associate in accordance with HIPAA Regulations. In the event of a breach or suspected breach of protected health information, the report to the Covered Entity must be in writing and include the following: a brief description of the incident; the date of the incident; the date the incident was discovered by the Business Associate; a thorough description of the unsecured protected health information that was involved in the incident; the number of individuals whose protected health information was involved in the incident; and the steps the Business Associate or its agent or subcontractor is taking to investigate the incident and to protect against further incidents. The Covered Entity will determine if a breach of unsecured protected health information has occurred and will notify the Business Associate of the determination. If a breach of unsecured protected health information is determined, the Business Associate must take prompt corrective action to cure any such deficiencies and mitigate any significant harm that may have occurred to individual(s) whose information was disclosed inappropriately.
8. **Breach Notification Requirements.** If the Covered Entity determines a breach of unsecured protected health information by the Business Associate, or its agents or subcontractors has occurred, the Business Associate will be responsible for notifying the individuals whose

unsecured protected health information was breached in accordance with HIPAA Regulations. The Business Associate must provide evidence to the Covered Entity that appropriate notifications to individuals and/or media, when necessary, as specified in HIPAA Regulations has occurred. The Business Associate is responsible for all costs associated with notification to individuals, the media or others as well as costs associated with mitigating future breaches. The Business Associate must notify the Secretary of all breaches in accordance with HIPAA Regulations and must provide the Covered Entity with a copy of all notifications made to the Secretary.

9. **Breach Pattern or Practice by Covered Entity.** Pursuant to HIPAA Regulations, if the Business Associate knows of a pattern of activity or practice of the Covered Entity that constitutes a material breach or violation of the Covered Entity's obligations under the Contract or Addendum, the Business Associate must immediately report the problem to the Secretary.
10. **Data Ownership.** The Business Associate acknowledges that the Business Associate or its agents or subcontractors have no ownership rights with respect to the protected health information it creates, receives or maintains, or otherwise holds, transmits, uses or discloses.
11. **Litigation or Administrative Proceedings.** The Business Associate shall make itself, any subcontractors, employees, or agents assisting the Business Associate in the performance of its obligations under the Contract or Addendum, available to the Covered Entity, at no cost to the Covered Entity, to testify as witnesses, or otherwise, in the event litigation or administrative proceedings are commenced against the Covered Entity, its administrators or workforce members upon a claimed violation by Business Associate of HIPAA Regulations or other laws relating to security and privacy.
12. **Minimum Necessary.** The Business Associate and its agents and subcontractors shall request, use and disclose only the minimum amount of protected health information necessary to accomplish the purpose of the request, use or disclosure in accordance with HIPAA Regulations.
13. **Policies and Procedures.** The Business Associate must adopt written privacy and security policies and procedures and documentation standards to meet the requirements of HIPAA Regulations.
14. **Privacy and Security Officer(s).** The Business Associate must appoint Privacy and Security Officer(s) whose responsibilities shall include: monitoring the Privacy and Security compliance of the Business Associate; development and implementation of the Business Associate's HIPAA Privacy and Security policies and procedures; establishment of Privacy and Security training programs; and development and implementation of an incident risk assessment and response plan in the event the Business Associate sustains a breach or suspected breach of protected health information.
15. **Safeguards.** The Business Associate must implement safeguards as necessary to protect the confidentiality, integrity and availability of the protected health information the Business Associate creates, receives, maintains, or otherwise holds, transmits, uses or discloses on behalf of the Covered Entity. Safeguards must include administrative safeguards (e.g., risk analysis and designation of security official), physical safeguards (e.g., facility access controls and workstation security), and technical safeguards (e.g., access controls and audit controls) to the confidentiality, integrity and availability of the protected health information, in accordance with HIPAA Regulations. Technical safeguards must meet the standards set forth by the guidelines of the National Institute of Standards and Technology (NIST). The Business Associate agrees to only use, or disclose protected health information as provided for by the Contract and Addendum and to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate, of a use or disclosure, in violation of the requirements of this Addendum as outlined in HIPAA Regulations.
16. **Training.** The Business Associate must train all members of its workforce on the policies and procedures associated with safeguarding protected health information. This includes, at a minimum, training that covers the technical, physical and administrative safeguards needed to prevent inappropriate uses or disclosures of protected health information; training to prevent any intentional or unintentional use or disclosure that is a violation of HIPAA Regulations; and training that emphasizes the criminal and civil penalties related to HIPAA breaches or inappropriate uses or disclosures of protected health information. Workforce training of new employees must be completed within 30 days of the date of hire and all employees must be trained at least annually. The Business Associate must maintain written records for a period of six years. These records

must document each employee that received training and the date the training was provided or received.

17. **Use and Disclosure of Protected Health Information.** The Business Associate must not use or further disclose protected health information other than as permitted or required by the Contract or as required by law. The Business Associate must not use or further disclose protected health information in a manner that would violate the requirements of HIPAA Regulations.

III. PERMITTED AND PROHIBITED USES AND DISCLOSURES BY THE BUSINESS ASSOCIATE

The Business Associate agrees to these general use and disclosure provisions:

1. **Permitted Uses and Disclosures:**
   a. Except as otherwise limited in this Addendum, the Business Associate may use or disclose protected health information to perform functions, activities, or services for, or on behalf of, the Covered Entity as specified in the Contract, provided that such use or disclosure would not violate HIPAA Regulations, if done by the Covered Entity.
   b. Except as otherwise limited in this Addendum, the Business Associate may use or disclose protected health information received by the Business Associate in its capacity as a Business Associate of the Covered Entity, as necessary, for the proper management and administration of the Business Associate, to carry out the legal responsibilities of the Business Associate, as required by law or for data aggregation purposes in accordance with HIPAA Regulations.
   c. Except as otherwise limited by this Addendum, if the Business Associate discloses protected health information to a third party, the Business Associate must obtain, prior to making such disclosure, reasonable written assurances from the third party that such protected health information will be held confidential pursuant to this Addendum and only disclosed as required by law or for the purposes for which it was disclosed to the third party. The written agreement from the third party must include requirements to immediately notify the Business Associate of any breaches of confidentiality of protected health information to the extent it has obtained knowledge of such breach.
   d. The Business Associate may use or disclose protected health information to report violations of law to appropriate federal and state authorities, consistent with HIPAA Regulations.
2. **Prohibited Uses and Disclosures:**
   a. Except as otherwise limited in this Addendum, the Business Associate shall not disclose protected health information to a health plan for payment or health care operations purposes if the patient has required this special restriction, and has paid out of pocket in full for the health care item or service to which the protected health information relates in accordance with HIPAA Regulations.
   b. The Business Associate shall not directly or indirectly receive remuneration in exchange for any protected health information, unless the Covered Entity obtained a valid authorization, in accordance with HIPAA Regulations that includes a specification that protected health information can be exchanged for remuneration.

IV. OBLIGATIONS OF THE COVERED ENTITY

1. The Covered Entity will inform the Business Associate of any limitations in the Covered Entity's Notice of Privacy Practices in accordance with HIPAA Regulations, to the extent that such limitation may affect the Business Associate's use or disclosure of protected health information.
2. The Covered Entity will inform the Business Associate of any changes in, or revocation of, permission by an individual to use or disclose protected health information, to the extent that such changes may affect the Business Associate's use or disclosure of protected health information.
3. The Covered Entity will inform the Business Associate of any restriction to the use or disclosure of protected health information that the Covered Entity has agreed to in accordance with HIPAA Regulations, to the extent that such restriction may affect the Business Associate's use or disclosure of protected health information.
4. Except in the event of lawful data aggregation or management and administrative activities, the Covered Entity shall not request the Business Associate to use or disclose protected health

information in any manner that would not be permissible under HIPAA Regulations, if done by the Covered Entity.

V. TERM AND TERMINATION

1. **Effect of Termination:**
   a. Except as provided in paragraph (b) of this section, upon termination of this Addendum, for any reason, the Business Associate will return or destroy all protected health information received from the Covered Entity or created, maintained, or received by the Business Associate on behalf of the Covered Entity that the Business Associate still maintains in any form and the Business Associate will retain no copies of such information.
   b. If the Business Associate determines that returning or destroying the protected health information is not feasible, the Business Associate will provide to the Covered Entity notification of the conditions that make return or destruction infeasible. Upon a mutual determination that return or destruction of protected health information is infeasible, the Business Associate shall extend the protections of this Addendum to such protected health information and limit further uses and disclosures of such protected health information to those purposes that make return or destruction infeasible, for so long as the Business Associate maintains such protected health information.
   c. These termination provisions will apply to protected health information that is in the possession of subcontractors, agents or employees of the Business Associate.
2. **Term**. The Term of this Addendum shall commence as of the effective date of this Addendum herein and shall extend beyond the termination of the contract and shall terminate when all the protected health information provided by the Covered Entity to the Business Associate, or accessed, maintained, created, retained, modified, recorded, stored or otherwise held, transmitted, used or disclosed by the Business Associate on behalf of the Covered Entity, is destroyed or returned to the Covered Entity, or if it is not feasible to return or destroy the protected health information, protections are extended to such information, in accordance with the termination.
3. **Termination for Breach of Contract.** The Business Associate agrees that the Covered Entity may immediately terminate the Contract if the Covered Entity determines that the Business Associate has violated a material part of this Addendum.

VI. MISCELLANEOUS

1. **Amendment.** The parties agree to take such action as is necessary to amend this Addendum from time to time for the Covered Entity to comply with all the requirements of HIPAA Regulations.
2. **Clarification.** This Addendum references the requirements of HIPAA Regulations, as well as amendments and/or provisions that are currently in place and any that may be forthcoming.
3. **Indemnification.** Each party will indemnify and hold harmless the other party to this Addendum from and against all claims, losses, liabilities, costs and other expenses incurred as a result of, or arising directly or indirectly out of or in conjunction with:
   a. Any misrepresentation, breach of warranty or non-fulfillment of any undertaking on the part of the party under this Addendum; and
   b. Any claims, demands, awards, judgments, actions, and proceedings made by any person or organization arising out of or in any way connected with the party's performance under this Addendum.
4. **Interpretation**. The provisions of this Addendum shall prevail over any provisions in the Contract that any conflict or appear inconsistent with any provision in this Addendum. This Addendum and the Contract shall be interpreted as broadly as necessary to implement and comply with HIPAA Regulations. The parties agree that any ambiguity in this Addendum shall be resolved to permit the Covered Entity and the Business Associate to comply with HIPAA Regulations.
5. **Regulatory Reference.** A reference in this Addendum to HIPAA Regulations means the sections as in effect or as amended.
6. **Survival.** The respective rights and obligations of Business Associate under Effect of Termination of this Addendum shall survive the termination of this Addendum.

IN WITNESS WHEREOF, the Business Associate and the Covered Entity have agreed to the terms of the above written agreement as of the effective date set forth below.

COVERED ENTITY	**BUSINESS ASSOCIATE**
Aging and Disability Services Division	_____ (Business Name)
3416 Goni Road, Building D-132	_____ (Business Address) (City,
Carson City, NV 89706	_____ State and Zip Code)
(775) 687-0532	_____ (Business Phone Number)
	_____ (Business FAX Number)
_____ (Authorized Signature)	_____ (Authorized Signature)
JANE GRUNER	_____ (Print Name)
Administrator	_____ (Title)
_____ (Date)	_____ (Date)

MINIMUM INSURANCE REQUIREMENTS

INDEMNIFICATION CLAUSE:

Contractor shall indemnify, hold harmless and, not excluding the State's right to participate, defend the State, its officers, officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against all liabilities, claims, actions, damages, losses, and expenses including without limitation reasonable attorneys' fees and costs, (hereinafter referred to collectively as "claims") for bodily injury or personal injury including death, or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of Contractor or any of its owners, officers, directors, agents, employees or subcontractors. This indemnity includes any claim or amount arising out of or recovered under the Workers' Compensation Law or arising out of the failure of such contractor to conform to any federal, state or local law, statute, ordinance, rule, regulation or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by Contractor from and against any and all claims. It is agreed that Contractor will be responsible for primary loss investigation, defense and judgment costs where this indemnification is applicable. In consideration of the award of this contract, the Contractor agrees to waive all rights of subrogation against the State, its officers, officials, agents and employees for losses arising from the work performed by the Contractor for the State.

INSURANCE REQUIREMENTS:

Contractor and subcontractors shall procure and maintain until all of their obligations have been discharged, including any warranty periods under this Contract are satisfied, insurance against claims for injury to persons or damage to property which may arise from or in connection with the performance of the work hereunder by the Contractor, his agents, representatives, employees or subcontractors.

The insurance requirements herein are minimum requirements for this Contract and in no way limit the indemnity covenants contained in this Contract. The State in no way warrants that the minimum limits contained herein are sufficient to protect the Contractor from liabilities that might arise out of the performance of the work under this contract by the Contractor, his agents, representatives, employees or subcontractors and Contractor is free to purchase additional insurance as may be determined necessary.

A. **MINIMUM SCOPE AND LIMITS OF INSURANCE:** Contractor shall provide coverage with limits of liability not less than those stated below. An excess liability policy or umbrella liability policy may be used to meet the minimum liability requirements provided that the coverage is written on a "following form" basis.

1. **Commercial General Liability – Occurrence Form**
   Policy shall include bodily injury, property damage and broad form contractual liability coverage.
   - General Aggregate $2,000,000
   - Products – Completed Operations Aggregate $1,000,000
   - Personal and Advertising Injury $1,000,000
   - Each Occurrence $1,000,000

   a. The policy shall be endorsed to include the following additional insured language: "The State of Nevada shall be named as an additional insured with respect to liability arising out of the activities performed by, or on behalf of the Contractor".

2. **Automobile Liability**
   Bodily Injury and Property Damage for any owned, hired, and non-owned vehicles used in the performance of this Contract.
   Combined Single Limit (CSL) $1,000,000

a. The policy shall be endorsed to include the following additional insured language: "The State of Nevada shall be named as an additional insured with respect to liability arising out of the activities performed by, or on behalf of the Contractor, including automobiles owned, leased, hired or borrowed by the Contractor".

3. **Worker's Compensation and Employers' Liability**

Workers' Compensation	Statutory
Employers' Liability	
Each Accident	$100,000
Disease – Each Employee	$100,000
Disease – Policy Limit	$500,000

a. Policy shall contain a waiver of subrogation against the State of Nevada.

b. This requirement shall not apply when a contractor or subcontractor is exempt under N.R.S., **AND** when such contractor or subcontractor executes the appropriate sole proprietor waiver form.

4. **Professional Liability (Errors and Omissions Liability)**
The policy shall cover professional misconduct or lack of ordinary skill for those positions defined in the Scope of Services of this contract.

Each Claim	$1,000,000
Annual Aggregate	$2,000,000

a. In the event that the professional liability insurance required by this Contract is written on a claims-made basis, Contractor warrants that any retroactive date under the policy shall precede the effective date of this Contract; and that either continuous coverage will be maintained or an extended discovery period will be exercised for a period of two (2) years beginning at the time work under this Contract is completed.

B. **ADDITIONAL INSURANCE REQUIREMENTS:** The policies shall include, or be endorsed to include, the following provisions:

1. On insurance policies where the State of Nevada is named as an additional insured, the State of Nevada shall be an additional insured to the full limits of liability purchased by the Contractor even if those limits of liability are in excess of those required by this Contract.

2 The Provider's insurance coverage shall be primary insurance and non-contributory with respect to all other available sources.

C. **NOTICE OF CANCELLATION:** Each insurance policy required by the insurance provisions of this Contract shall provide the required coverage and shall not be suspended, voided or canceled except after thirty (30) days prior written notice has been given to the State, except when cancellation is for non-payment of premium, then ten (10) days prior notice may be given. Such notice shall be sent directly to: *State of Nevada, Aging and Disability Services Division, 3416 Goni Road Building D Suite #132 Carson City, NV 89706, "Attention Contracts".*

D. **ACCEPTABILITY OF INSURERS:** Insurance is to be placed with insurers duly licensed or authorized to do business in the state of Nevada and with an "A.M. Best" rating of not less than A-VII. The State in no way warrants that the above-required minimum insurer rating is sufficient to protect the Contractor from potential insurer insolvency.

E. **VERIFICATION OF COVERAGE:** Contractor shall furnish the State with certificates of insurance (ACORD form or equivalent approved by the State) as required by this Contract. The certificates for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf.

All certificates and any required endorsements are to be received and approved by the State before work commences. Each insurance policy required by this Contract must be in effect at or prior to commencement of work under this Contract and remain in effect for the duration of the project. Failure to maintain the insurance policies as required by this Contract or to provide evidence of renewal is a material breach of contract.

All certificates required by this Contract shall be sent directly to: *State of Nevada, Aging and Disability Services Division, 3416 Goni Road Building D Suite #132 Carson City, NV 89706, "Attention Contracts"*. The State project/contract number and project description shall be noted on the certificate of insurance. The State reserves the right to require complete, certified copies of all insurance policies required by this Contract at any time.

F. **SUBCONTRACTORS:** Contractors' certificate(s) shall include all subcontractors as additional insured's under its policies **or** Contractor shall furnish to the State separate certificates and endorsements for each subcontractor. All coverage's for subcontractors shall be subject to the minimum requirements identified above.

G. **APPROVAL:** Any modification or variation from the insurance requirements in this Contract shall be made by the Risk Management Division or the Attorney General's Office, whose decision shall be final. Such action will not require a formal Contract amendment, but may be made by administrative action.

SECTION B – PROFESSIONAL SERVICE AGREEMENTS

Professional Contracts – Working with Children/Elderly or Disabled Persons

Many professional services involve working with or caring for children, the elderly, physically or developmentally disabled people. When these clients are in the care, custody or control of the contractor it creates an additional risk of liability for the State because of the severe and sensitive nature of the possible allegations of wrong-doing.

When services involve working with these groups of individuals, the insurance requirements in the contract need to be revised to include coverage for **"sexual molestation and physical abuse"**.

Coverage for this type of claim, or allegation, is excluded from standard general liability policies. Therefore, contractors whose services include working with and/or caring for children and disabled persons should have their policies specifically endorsed to include this coverage.

In addition to the standard requirements of general liability, automobile liability, professional liability and workers' compensation insurance, the specifications included in this section also require coverage for sexual molestation and physical abuse.

For those contracts where providers are involved in providing extensive in-home services, we have also included additional specifications for crime coverage. This coverage would be necessary to protect the client's loss of values or property. Crime polices should be endorsed to **include third party fidelity coverage** and list State of Nevada and the state clients' as **Loss Payee**.

Below is a reference checklist for your required insurance coverage:

VERIFICATION OF COVERAGE: Contractor shall furnish the State with certificates of insurance "(ACORD" form or equivalent approved by the State) as required by this Contract. The certificates for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf.

☐ 1. **Commercial General Liability – Occurrence Form**
Policy shall include bodily injury, property damage and broad form contractual liability coverage.

a. General Aggregate	$2,000,000
b. Products -- Completed Operations Aggregate	$1,000,000
c. Personal and Advertising Injury	$1,000,000
d. Each Occurrence	$1,000,000

*The policy shall be endorsed to include the following additional insured language: "The State of Nevada shall be named as an additional insured with respect to liability arising out of the activities performed by, or on behalf of the Contractor".

☐ 2. **Automobile Liability**
Bodily Injury and Property Damage for any owned, hired, and non-owned vehicles used in the performance of this Contract.

a. Combined Single Limit (CSL)	$1,000,000

☐ 3. **Worker's Compensation and Employers' Liability**

a. Workers' Compensation	Statutory
b. Employers' Liability	
i. Each Accident	$100,000
ii. Disease – Each Employee	$100,000
iii. Disease – Policy Limit	$500,000

☐ 4. **Professional Liability (Errors and Omissions Liability)**
The policy shall cover professional misconduct or lack of ordinary skill for those positions defined in the Scope of Services of this contract.

a. Each Claim	$1,000,000
b. Annual Aggregate	$2,000,000

☐ 5. **Sexual molestation and physical abuse** $100,000

☐ 6. **Fidelity Bond or Crime coverage** $100,000

☐ 7. **Additional Insurance Requirements:**
The policies shall include, or be endorsed to include the following provisions:

a. On insurance policies where the State of Nevada is named as an additional insured, the State of Nevada shall be an additional insured to the full limits of liability purchased by the Contractor even if those limits of liability are in excess of those required by this Contract.
b. The Provider's insurance coverage shall be primary insurance and non-contributory with respect to all other available sources.

Independent Provider's Signature	Date	Title	
Signature-State of Nevada	Date	Title	

SCOPE OF WORK
PROGRAM TYPE: TITLE XX HOMEMAKER PROGRAM
SERVICE: HOMEMAKER

DEFINITION:

HOMEMAKER SERVICES

- Meal preparation: menu planning, storing, preparing, serving of food, cutting up food, buttering bread and plating food.
- Laundry services: washing, drying and folding the recipient's personal laundry and linens (sheets, towels, etc.) excludes ironing.
- Light housekeeping: changing the recipient's bed linens, dusting, vacuuming the recipient's living area, cleaning kitchen and bathroom areas;
- Essential shopping to obtain: prescribed drugs, medical supplies, groceries, and other household items required specifically for the health and maintenance of the Recipient.
- Assisting the recipient and family members or caregivers in learning homemaker routine and skills, so the recipient may carry on normal living when the homemaker is not present.
- Reimbursement rates for services

Signature: _____ Date: _____

SCOPE OF WORK
PROGRAM TYPE: COMMUNITY OPTIONS PROGRAM for the ELDERLY (COPE)
SERVICE: ATTENDANT

DEFINITION:

PERSONAL CARE SERVICES/ATTENDANT

Assistance with the normal ADLs as described below:

- Assistance with bathing/dressing/grooming.
- Assistance with toileting needs and routine care of an incontinent recipient.
- Assistance with transferring and positioning non-ambulatory recipients from one stationary position to another, including adjusting/changing recipient's position in a bed or chair.
- Assistance with ambulation, which is the process of moving between locations, including walking or helping the recipient to walk with support of a wheelchair, walker, cane or crutches, assisting a recipient out of bed, chair or wheelchair.
- Assistance with eating, including cutting up food. Specialized feeding techniques may not be used.
- Assistance with medications which are self-administered, including verbal reminders to the recipient to take medications, bringing medication to the recipient and loosening the cap to the medication container. Medication administration by a Personal Care Attendant (PCA) is not permitted.
- Reimbursement rates for services

Signature: _____ Date: _____

SCOPE OF WORK
PROGRAM TYPE: COMMUNITY OPTIONS PROGRAM for the ELDERLY (COPE)
SERVICE: HOMEMAKER

DEFINITION:

HOMEMAKER SERVICES

- Meal preparation: menu planning, storing, preparing, serving of food, cutting up food, buttering bread and plating food.
- Laundry services: washing, drying and folding the recipient's personal laundry and linens (sheets, towels, etc.) excludes ironing.
- Light housekeeping: changing the recipient's bed linens, dusting, vacuuming the recipient's living area, cleaning kitchen and bathroom areas;
- Essential shopping to obtain: prescribed drugs, medical supplies, groceries, and other household items required specifically for the health and maintenance of the Recipient.
- Assisting the recipient and family members or caregivers in learning homemaker routine and skills, so the recipient may carry on normal living when the homemaker is not present.
- Reimbursement rates for services

Signature: _____ Date: _____

SCOPE OF WORK
PROGRAM TYPE: COMMUNITY OPTIONS PROGRAM for the ELDERLY (COPE)
SERVICE: ADULT DAY CARE

DEFINITION:

SOCIAL MODEL ADULT DAYCARE

- Day Care Service provided for four (4) or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting. Day care centers provide care and supervision, the monitoring of general health, social interaction and peer contact for the physically or mentally impaired or socially isolated adult in order that he or she can remain in the community.
- It encompasses social service needs to ensure the optimal functioning of the recipient.
- Meals provided are furnished as part of the program but must not constitute a "full nutritional regime" (i.e., three meals per day).
- Reimbursement rates for services

Signature: _____ Date: _____

SCOPE OF WORK
PROGRAM TYPE: COMMUNITY OPTIONS PROGRAM for the ELDERLY (COPE)
SERVICE: ADULT COMPANION

DEFINITION:

ADULT COMPANION SERVICES

- Provides non-medical care, supervision and socialization to a functionally impaired recipient in his or her home or place of residence, which may provide temporary relief for the primary caregiver.
- Adult companions may assist the recipient with such tasks as meal preparation and clean up, light housekeeping, shopping and facilitate transportation/escort as needed. These services are provided as an adjunct to the Adult Companion Services and must be incidental to the care and supervision of the recipient.
- The provision of Adult Companion Services does not entail hands-on medical care.
- Reimbursement rates for services

Signature: _____ Date: _____

SCOPE OF WORK
PROGRAM TYPE: COMMUNITY OPTIONS PROGRAM for the ELDERLY (COPE)
SERVICES: CHORE

DEFINITION:

CHORE SERVICE

Extended and intermittent homemaker service needed to maintain the recipient's living space as a clean, sanitary, and safe environment.

This service includes heavy household chores in the private residence such as:

- Cleaning windows and walls
- Shampooing carpets
- Tacking down loose rugs and tiles
- Moving heavy items of furniture in order to provide safe access
- Packing and unpacking for the purpose of relocation
- Minor home repairs
- Removing trash and debris from the yard
- Reimbursement rates for services

Signature: _____ Date: _____

SCOPE OF WORK
PROGRAM TYPE: COMMUNITY OPTIONS PROGRAM for the ELDERLY (COPE)
SERVICE: RESPITE CARE

DEFINITION:

RESPITE SERVICE

Refers to those services provided to eligible recipients who are unable to care for themselves. These services are furnished on a short-term, temporary basis because of the absence of or need for relief of those persons normally providing the care.

Perform general assistance with ADLs and IADLs and provide supervision to functionally impaired recipients in their private home such as:

- Have the ability to read and write and to follow written or oral instructions.
- Have had experience and/or training in providing for the personal care needs of people with functional impairments.
- Demonstrate the ability to perform the care tasks as prescribed.
- Be tolerant of the varied lifestyles of the people served.
- Arrange training in personal hygiene needs and techniques for assisting with ADLs, such as bathing, grooming, skin care, transferring, ambulating, feeding, dressing and use of adaptive aids and equipment, homemaking and household care.
- Respite care may occur in the recipient's private home.
- Reimbursement rates for services

Signature: _____ Date: _____

SCOPE OF WORK
PROGRAM TYPE: COMMUNITY OPTIONS PROGRAM for the ELDERLY (COPE)
SERVICE: PERSONAL RESPONSE SYSTEM (PERS)

DEFINITION:

PERSONAL EMERGENCY RESPONSE SYSTEM

- PERS is an electronic device, which enables certain recipients at high risk of institutionalization to secure help in an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to the recipient's phone and programmed to signal a response center once a "help" button is activated.
- PERS services are limited to those recipients who live alone in a private residence, or who are alone for significant parts of the day in that residence, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.
- Reimbursement rates for services

Signature: _____ Date: _____

SCOPE OF WORK
PROGRAM: PERSONAL ASSISTANCE SERVICES (PAS)
SERVICE: Standard, Non-medical Personal Care Services

Definition:

Personal Assistance Services is the provision of a trained individual to assist persons with physical disabilities with activities of daily living. The In-Home Personal Care Attendant must meet the attached requirements as established by the Aging and Disability Services Division.

Elements of Personal Assistance Services include assistance with:

1) Elimination of wastes from the body
2) Dressing and undressing
3) Bathing and grooming
4) Preparation and eating of meals
5) Getting in and out of bed
6) Repositioning while asleep
7) Use of prostheses and other medical equipment
8) Moving about, including, without limitation, assisting a person
    a) moving from a wheelchair, bed or other piece of furniture
    b) ambulation; and
    c) exercises to increase the range of motion
9) Essential laundry
10) Support services for independent living if the person has an injury to the brain and those services do not exceed 14 hours per week
11) Other minor needs directly related to maintenance of personal hygiene
12) Respite Care

Reimbursement for PAS Services is $17 per hour.

Signature: _____ Date: _____

SCOPE OF WORK
PROGRAM: PERSONAL ASSISTANCE SERVICES (PAS)
SERVICE: PERSONAL CARE SERVICES AS AN INTERMEDIARY SERVICE ORGANIZATION (ISO)

DEFINITION:

INTERMEDIARY SERVICE ORGANIZATION - (ISO)

An ISO is an entity that provides personal assistance services under the Self-Directed Care model. The ISO acts as an employer of record, providing both fiscal and supportive intermediary services such as administrative, limited program and specific payroll responsibilities for the delivery of personal assistance services. An individual accesses the services of an ISO either because they desire to self-manage their services, or because they receive skilled services and NRS 449 requires that such services be provided through an ISO.

SELF-DIRECTED SKILLED SERVICES

Specific medical, nursing, or home health services that a person without a disability usually and customarily would personally perform, without the assistance of a provider of health care. Such services may be provided for a person with a disability by a personal care assistant without obtaining any license required for a provider of health care or his assistance, under very specific circumstances pursuant to NRS 629.091.

Signature: _____ Date: _____

SCOPE OF WORK
PROGRAM TYPE: ELDER RIGHTS
SERVICE: EPS HOMEMAKER

DEFINITION:

Homemaker services are the provision of an individual to conduct homemaking activities for at risk clients.

Services include:

- Teaching and providing home management skills
- Preparing meals
- Transporting meals from senior nutrition site
- General cleaning
- Floor care
- Dusting
- Laundry
- Shopping
- Other miscellaneous duties as specified by the Aging and Disability Services Division to provide a safe and sanitary living environment for the client.

RATE:

The reimbursement rate for EPS Homemaker services is the same as Medicaid's homemaker rate.

Signature: _____ Date: _____

SCOPE OF WORK
PROGRAM TYPE: ELDER RIGHTS
SERVICE: MENTAL CAPACITY EVALUATIONS

DEFINITION:

Mental capacity evaluations are used to determine an individual's capacity to make sound judgments and live independently. These evaluations are critical in determining mental capacity and the right to self determination. The evaluations will be used to determine a client's need for legal guardianship, either of the person, estate or both.

Services include:

- Conducting mental capacity evaluations as soon as possible, but no later than 10 business days from referral. The evaluation will determine a client's need for a guardianship, either of the person, estate, or both.
- Conducting evaluations at the client's place of residence, unless the client is willing and able to travel to the physician's office for the evaluation.
- Providing ADSD with a full written report of the findings, conclusions and recommendations regarding the client's need for a guardianship within 7-10 working days of the evaluation, including a copy of the evaluation and invoice for services.
- Completing the *Certificate of Incapacity* and *Admonishment of Rights* forms when a guardianship is recommended and return these forms with the written evaluation.

SCOPE OF WORK
PROGRAM TYPE: ELDER RIGHTS
SERVICE: MENTAL CAPACITY EVALUATIONS

MINIMUM QUALIFICATIONS:

Must be a licensed physician in Nevada with education and experience in the field of geriatrics and/or mental health and guardianships.

RATE:

Mental capacity evaluations will be reimbursed at a rate of $400 per evaluation plus travel expenses as defined. Travel expenses are defined as follows: Travel mileage will be reimbursed at the state rate of $.56 ½ per mile. Mileage calculation begins at the providers usual work location or wherever the provider is starting from, whichever is less. Meals will be reimbursed at the GSA (General Services Administration) rate if travel occurs beyond 50 miles of the providers normal work station and during meal hours. Meal hours are defined as leaving at or before 7:00 am for breakfast, leaving at or before 11:00 am and returning after 1:30 pm for lunch, and leaving at or before 5:30 pm and returning after 7:00 pm for dinner. (http://www.gsa.gov/portal/content/101518)

Signature: _____ Date: _____

SCOPE OF WORK
PROGRAM TYPE: ELDER RIGHTS
SERVICE: Temporary Assistance for Displaced Seniors

DEFINITION:

Temporary Assistance to Displaced Seniors (TADS) is the provision of providing temporary, short term housing to Elder Protective Services clients in a licensed group home.

Services include:

- Screening of clients referred by ADSD for *immediate* placement upon provider's determination client's needs can be met.
- To provide usual and customary services to displaced seniors in need of temporary assistance.
  - Coordinate and arrange for all necessary admission protocols including but not limited to medical screenings, transportation to medical appointments, and obtaining prescription medication.
- Services are generally provided for no more than 30 days until alternate housing arrangements can be established or other arrangements have been made with the authorizing ADSD office.

MINIMUM QUALIFICATIONS:

Housing provided must be in a facility licensed by and in good standing with the Bureau of Health Care Quality and Compliance (HCQC). The facility must maintain a rating of "B" or better. The facility is required to notify ADSD if their grade falls below a "B". The notification shall be in writing and shall be within 10 business days of having received the rating.

RATE:

TADS placements will be paid at $100 per day.

Signature: _____ Date: _____

COMMUNITY BASED SERVICES

SERVICE PROVIDER MANUAL

State of Nevada – Department of Health and Human Services
Aging and Disability Services Division
3416 Goni Road, Suite D - 132
Carson City, Nevada 89706
Phone 775-687-4210; *Fax* 775-687-4264
adsd@adsd.nv.gov

Revised 8/11

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COMMUNITY BASED SERVICES
SERVICE PROVIDER MANUAL

The billing procedures addressed in this manual refer to the Community Options Program for the Elderly (COPE), the Title XX Homemaker Program and the Personal Assistance Services (PAS) program. Providers must be contracted as providers through Medicaid before they can provide COPE and Homemaker services.

1.0 Service Authorization

1.1 Case managers will authorize all waiver and personal care services to be provided for each client. ADSD will only reimburse providers for services authorized by case managers.

1.2 When a client is approved for a program, the case manager will complete a *Plan of Care and Provider Service Authorization Form.* This information will be faxed to the provider, and a copy of the *Plan of Care and Provider Service Authorization Form* will be mailed to the provider. Services cannot be started until this approval is received by the provider.

1.3 The service provider will inform the case manager of any changes in the provision of services for each client. The case manager must approve any changes in the delivery of services to the client. Permanent changes will require a new Plan of Care.

1.4 Plans of Care are valid for no longer than 12 months. Case managers will reauthorize services yearly or sooner if a client's condition warrants a change.

2.0 Transportation

2.1 Providers are prohibited from transporting clients. ADSD will not reimburse any provider for transporting clients for any reason.

2.2 Providers may only accompany clients to doctor appointments or shopping via public transportation, e.g., taxies, senior transportation.

3.0 Medical Services

Community Based Services is a non-medical program. Providers may not perform any medical services. ADSD will not reimburse a provider for any services not noted on the Plan of Care. The case manager should be contacted if there are any questions regarding the tasks to be performed.

4.0 Client Verification

4.1 Providers are responsible for obtaining client verification of the dates, times, amounts and types of service provided. Each document must contain original signatures and be obtained on the date of service. Original client verification logs must be retained in the client file.

4.2 If a client has difficulty signing the service verification form, the client may sign his/her initials only.

4.3 If a client is unable to sign the service verification form, a designated representative for the client may sign the form.

4.4 The case manager must approve the use of an "X" if the client cannot sign his/her name or initials or there is no designated representative who can sign the form.

5.0 Cancellation of Service and Holidays

5.1 Whenever possible, the client or case manager will cancel services by notifying the provider 24 hours in advance.

5.5 Services are not authorized on State authorized holidays. Any services provided on these days must be authorized by the case manager and will be paid at the regular rate.
The State of Nevada currently recognizes the following holidays: New Year's Day, Martin Luther King Day, President's Day, Memorial Day, Independence Day, Labor Day, Nevada Admission Day

(last Friday in October), Veteran's Day, Thanksgiving Day, Family Day (the day after Thanksgiving), and Christmas Day.

6.0 Client Not at Home/Client Refuses Services

6.5 The provider is responsible for contacting clients prior to the in-home visit to ensure the client will be home. Provider will not be reimbursed for a visit where a client was not at home.

6.6 ADSD defers to the Medicaid Services Manual Section 3503.10(5): Reimbursement: "The rate takes into consideration, and includes, the costs associated with doing business. Separate reimbursement is not available."

Reimbursement

The reimbursement rate is based on a contracted rate which takes into consideration and includes the costs associated with doing business. Consequently, separate reimbursement is not available for the following:

a. Time spent completing administrative functions such as supervisory visits, scheduling, chart audits, surveys, review of service delivery records, and personnel consultant;
b. The cost of criminal background checks and TB testing;
c. Travel time to and between clients home;
d. The cost of basic training, in-service requirements, and the CPR and First Aid requirement; and/or
e. Routine supplies customarily used during the course of visits, including but not limited to non-sterile gloves.

7.0 Billing Procedures

7.5 Bills will only cover a one-month period, i.e., portions of previous or subsequent months are not to be included. For example, the bill for June is to cover June 1 through 30 only. Do not include any days for May or July.

7.6 Billing Format

Bills will include:

A. Summary invoice showing all invoices included (refer to forms section for instructions on completing the summary invoice).
B. Provider invoice for each client.
A. Client verification logs (explained in Section 4.0) for each client attached to the original provider invoice for the client. Copies of client verification logs are acceptable, attached to original invoices.

7.7 Provider Invoices:

A. A Provider invoice must be completed at least monthly for each client. (Refer to forms section for instructions on completing the provider invoice.)
B. Providers may computerize the form for their own convenience as long as the format remains intact.
C. Client Verification Logs (copies can be submitted with billing, original client logs must be retained in the client file) must be attached to the original provider invoice for each client.
D. ADSD will not reimburse providers for service without client verification of the dates, amount and types of service provided.
E. The provider name and address must be the same as listed on the contract. ADSD must be notified in writing of any changes. The provider is also responsible for reporting any name and address changes or deletions to Vendor Services at the State Controller's office.

7.8 Submission of Bills

A. Bills are to be submitted to the local ADSD offices (see attached Billing Addresses). Individual invoices will be in duplicate and summary invoices in triplicate.

B. Bills will be submitted by the 10th day of the following month.

C. Reimbursement for bills submitted later than the 10th day of the following month may be delayed.

8.0 Payment of Bills

8.5 Bills will be reviewed for accuracy and compliance as to type and amount of services authorized.

8.6 Bills reviewed and approved by the local ADSD office are then submitted to the ADSD fiscal unit for payment. Incorrect bills will be returned to the provider per Section 9.0

8.7 The State Controller will issue a check for distribution. Checks are mailed directly to the Service Provider. The payment process may take up to 4 weeks after ADSD has received a complete and correct bill.

8.8 A copy of the summary invoice will be attached to the check to reflect which services are being paid with the check.

9.0 Incorrect Bills

Incorrect Provider invoices and accompanying documentation will be returned to service providers within 5 working days of receipt. A revised provider invoice and accompanying documentation must be returned to the local ADSD office within 5 working days.

10.0 Stale-dated Bills

10.5 Bills that are submitted more than 45 days after services are provided are considered "stale-dated claims."

10.6 ADSD will not reimburse providers for stale-dated claims unless documented good cause is shown why the bill was not submitted in a timely manner. An example of good cause would be an event or disaster that disrupts normal services.

11.0 Adjustments to Bills

Occasionally, an overpayment or underpayment may be made. When this occurs, a letter will be sent to the service provider explaining what has occurred and how the adjustment will be made.

12.0 Questions on Payment

Questions on payment of submitted bills should be directed to the ADSD Contract Unit in the Carson City office at 775-687-4210, ext.280.

13.0 Charges to the Client

The service provider must not bill any CBS client directly for services delivered that were authorized under the CBS program. Donations may not be solicited nor additional fees levied against the client for services reimbursed by CBS. Providers should not discuss payment or charges with the client.

14.0 Tips/Gifts

Providers must not accept tips or gifts from clients.

15.0 Record Retention

Providers are required to retain a client's records for six (6) years.

15.5 Medicaid Service Manual Chapter 2203.2B(h)

ADSD defers to the Medicaid Service Manual Chapter 2203.2B(h) which states:

(h) Each provider agency must have a file for each client. In the client's file, the agency must document the actual time spent providing services and the services provided. Periodically, Medicaid Central Office staff may request this documentation to compare it to billings submitted. These records must be maintained by the provider for at least six years after the date the claim is paid.

15.6 Medicaid Service Manual Chapter 3503.1b (23.a, 23.b)

ADSD defers to the Medicaid Service Manual Chapter 3503.1B (23.a, 23.b) for PCA services which states:

23.a The provider must maintain medical and financial records, supporting documents, and all other records relating to services provided under this program. The provider must retain records for a period pursuant to the State record retention policy, which is currently six years from the date the service is ended. If any litigation, claim, or audit is started before the expiration of the retention period provided by the Division of Health Care Financing and Policy (DHCFP), records must be retained until all litigation, claims, or audit findings have been finally determined.

1. The Provider must maintain all required records for each PCA employed by the agency, regardless of the length of employment.
2. The Provider must maintain the required record for each client who has been provided services, regardless of length of service period.

23.b At a minimum, the Provider must document the following on all service records:

1. Consistent service delivery within program requirements;
2. Amount of services provided to clients;
3. When services were delivered; and
4. The PCA must sign the daily record form, attesting to the service given and the time spent providing the service.

16.0 Guidelines for Use of Serious Occurrence Report

As a provider of services for client's enrolled in the Home and Community Based Services programs, you are required to complete a Serious Occurrence Report (SOR) form NMO 3430-E when you become aware of a serious occurrence. These programs include CHIP, COPE, WEARC, AL, PAS and Homemaker.

ADSD defers to the Medicaid Service Manual Chapter 3503.1b 20:

20. Serious occurrences involving either the PCA or client may include, but are not limited to the following:

a. Suspected physical or verbal abuse;
b. Neglect of the client;
c. Sexual harassment or sexual abuse;
d. Injuries requiring medical intervention;
e. An unsafe working environment;
f. Any event which is reported to Child or Elder Protective Services or law enforcement agencies;

g. Death of the client during the provision of Personal Care Services; and
h. Loss of contact with the client for three consecutive scheduled days.

In addition:

- Falls
- Unplanned hospitalizations to include ER visits

The SOR lists many examples of events to report.

A Serious Occurrence may involve the client, the provider's staff, or anything affecting the provider's ability to deliver services. The SOR must be completed and faxed within 24 hours of discovery to the local ADSD office.

Completing the form:

- Identify which program the client is enrolled in.
  - If Homemaker client you will need to write "HM"
- Make sure documentation is legible
- State facts, not opinions
- Fill in all requested names, numbers, signatures
  - The listed supervisor name should be the contact person for follow up questions
- Address all bolded areas
  - Mark N/A if not applicable
- Be thorough and specific on action taken
  - Space is limited so attach additional paper/narrative as needed

A summary report of serious occurrences must be submitted in January and July of each year to the Quality Management Unit of Aging and Disability Services Division, 3416 Goni Road, D - #132, Carson City, NV 89706.

AGING AND DISABILITY SERVICES DIVISION
COMMUNITY BASED SERVICES
CLIENT VERIFICATION LOG

COPE PROGRAM

Last Name _____ First Name _____ M.I.___

Billing Dates _____

DAY	DATE	FROM:	TO:	Attendant	Home maker	** _____	PROVIDER SIGNATURE	CLIENT SIGNATURE
SUN								
MON								
TUE								
WED								
THU								
FRI								
SAT								

DAY	DATE	FROM:	TO:	Attendant	Home maker	** _____	PROVIDER SIGNATURE	CLIENT SIGNATURE
SUN								
MON								
TUE								
WED								
THU								
FRI								
SAT								

** Other Services: Respite, Adult Companion

(Note) Top section is for the first week of the billing period. Bottom section is for the second week of the billing period

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AGING AND DISABILITY SERVICES DIVISION
COMMUNITY BASED SERVICES
CLIENT VERIFICATION LOG

PAS PROGRAM

Last Name _____ First Name _____ M.I.___

Billing Dates _____

DAY	DATE	FROM:	TO:	ASSISTANT	PROVIDER SIGNATURE	CLIENT SIGNATURE
SUN						
MON						
TUE						
WED						
THU						
FRI						
SAT						

DAY	DATE	FROM:	TO:	ASSISTANT	PROVIDER SIGNATURE	CLIENT SIGNATURE
SUN						
MON						
TUE						
WED						
THU						
FRI						
SAT						

(Note) Top section is for the first week of the billing period. Bottom section is for the second week of the billing period

AGING AND DISABILITY SERVICES DIVISION
COMMUNITY BASED SERVICES
CLIENT VERIFICATION LOG INSTRUCTIONS

LAST: Enter last name of client.

FIRST: Enter first name of client.

M.I.: Enter middle initial of client.

BILLING DATES: Self-explanatory.

DATES: Enter dates of service.

FROM COLUMN: Enter time service begins.

TO COLUMN: Enter time service ends.

ATTENDANT COLUMN: Enter units of attendant services on the corresponding day/date line.

HOMEMAKER COLUMN: Enter units of homemaker services on the corresponding day/date line.

OTHER SERVICE: Enter type of service, i.e., "Companion," "Day Care," "Respite."

ASSISTANT COLUMN: Enter units of assistant services on the corresponding day/date line.

OF UNITS RECEIVED: enter number of units of service, e.g. 1 unit = 15 minutes of service for attendant, assistant, homemaker and companion. Based on prior authorizations provided by ADSD, day care and respite may have an hourly rate or a daily maximum rate.

PROVIDER SIGNATURE: signature of worker providing service.

CLIENT SIGNATURE: Initials are acceptable if client has difficulty signing due to physical limitations. Social worker must approve the use of an "X" or signature stamp.

(Note) Top section is for the first week of the billing period. Bottom section is for the second week of the billing period.

AGING AND DISABILITY SERVICES DIVISION
COMMUNITY BASED SERVICES
PROVIDER INVOICE

PROVIDER NAME

PROVIDER ADDRESS PHONE

CLIENT NAME CLIENT ADDRESS

BILLING FOR MO/DAY THRU MO/DAY YEAR

TYPE OF SERVICE	DATES OF SERVICE	TOTAL UNITS	RATE	TOTAL
			TOTAL BILLED	

I HEREBY CERTIFY THIS BILL CORRECTLY REFLECTS ACTUAL SERVICES DELIVERED AS AUTHORIZED BY ADSD.

By_____ Date_____
Signature

FOR CBS UNIT USE ONLY

DO RECEIPT_____ _____
DATE **INITIALS**

CO RECEIPT_____ _____ **PAID**_____ _____
DATE **INITIALS** **DATE** **VOUCHER**

AGING AND DISABILITY SERVICES DIVISION
COMMUNITY BASED SERVICES
PROVIDER INVOICE INSTRUCTIONS

1. One invoice is to be completed for each COPE/Homemaker/PAS client monthly or twice a month for services delivered (i.e. January 1-January 15, 20--; January 16-January 31, 20--).

2. Complete legibly the:

   A. Provider name
   B. Provider address for mailing reimbursement
   C. Provider phone
   D. Client name
   E. Client address
   F. Month and day billing begins and ends and year

3. Enter type of service (i.e., homemaker, attendant, assistant, adult day care) delivered. Codes or abbreviations are not acceptable.

4. Enter days of service (each day services were provided; example: 2, 5, 7, 10, 15, 30.) Range is acceptable only if service was provided on all days.

5. Enter total units provided.

6. Enter total cost for units in #5.

7. Total of monies owed to the provider is to be entered.

8. The *Bill* and the *Billing Summary* are to be signed and dated by the individual responsible for billing.

9. Bills are to be mathematically correct and correspond to services delivered/authorized by ADSD and verified by ADSD client.

10. Bills that are not correct will be returned to the provider thereby delaying reimbursement.

11. Submitting Invoices. The following documentation must be included with all client invoices, and submitted in the order below:
    1. The original invoice;
    2. One copy of the invoice attached to the original;
    3. One copy (needs to be an original) of each timesheet attached to the invoice.

    Any questions on invoice submittal must be directed to the Administrative Assistant for each regional office. Please see the attached list of "Invoice Contacts" for the names and contact information of the Administrative Assistants in the ADSD regional offices.

CBS BILLING SUMMARY

BILL TO:

Aging and Disability Services Division

PROVIDER:

Prov Phone #:

BILLING DATES

RATE PER UNIT

Attendant	Homemaker
$ -	$ -

CLIENT	ATTENDANT UNITS	HOMEMAKER UNITS	ATTENDANT AMOUNT	HOMEMAKER AMOUNT	AMOUNT DUE
List clients in Alphabetical Order					
	-	-	$ -	$ -	$ -
	-	-	$ -	$ -	$ -
	-	-	$ -	$ -	$ -
	-	-	$ -	$ -	$ -
	-	-	$ -	$ -	$ -
	-	-	$ -	$ -	$ -
	-	-	$ -	$ -	$ -
	-	-	$ -	$ -	$ -
	-	-	$ -	$ -	$ -
	-	-	$ -	$ -	$ -
TOTAL	-	-	$ -	$ -	$ -

I HEREBY CERTIFY THIS BILL CORRECTLY REFLECTS ACTUAL SERVICES DELIVERED AS AUTHORIZED BY ADSD.

BY: _____ **DATE:** _____

BILLING SUMMARY
SAMPLE

BILL TO:	PROVIDER:			BILLING DATES	
Aging and Disability Services Division (Local Office Address) (Local Office Address)	(Provider Name) (Provider Address) (Provider City, State, Zip) (Provider Phone #)			RATE PER UNIT (Type of Svc) (Rate)	(Type of Svc) (Rate)
	(Type of Svc)	(Type of Svc)	(Type of Svc)	(Type of Svc)	AMOUNT
CLIENT	UNITS	UNITS	AMOUNT	AMOUNT	DUE
List clients in Alphabetical Order					
(Client Name)	(# of Units)	(# of Units)	(Att Amt)	(Hm Amt)	(Amount Due)
(Client Name)	(# of Units)	(# of Units)	(Att Amt)	(Hm Amt)	(Amount Due)
(Client Name)	(# of Units)	(# of Units)	(Att Amt)	(Hm Amt)	(Amount Due)
(Client Name)	(# of Units)	(# of Units)	(Att Amt)	(Hm Amt)	(Amount Due)
TOTAL	(Total Svc A Units)	(Total Svc B Units)	(Total Svc A Amt)	(Total Svc B Amt)	(Total Amount Due)

I HEREBY CERTIFY THIS BILL CORRECTLY REFLECTS ACTUAL SERVICES DELIVERED AS AUTHORIZED BY ADSD.

By: **To be signed and dated by individual responsible for billing**. Date:

BILLING ADDRESSES

COPE /HOMEMAKER BILLING

Carson City Administrative Office
3416 Goni Road #132
Carson City, Nevada 89706
Phone: 775-687-4210
Fax: 775-687-4264

Reno Regional Office
445 Apple Street #104
Reno, Nevada 89502
Phone: 775-688-2964
Fax: 775-688-2969

Las Vegas Regional Office
1860 East Sahara Avenue
Las Vegas, Nevada 89104
Phone: 702-486-3545
Fax: 702-486-3569

Elko Regional Office
1010 Ruby Vista Drive, Suite 104
Elko, Nevada 89801
Phone: 775-738-1966
Fax: 775-753-8543

PAS BILLING

NORTHERN NEVADA

Reno Regional Office
445 Apple Street #104
Reno, NV 89502
Phone: 775-688-2964
Fax: 775-688-2969

SOUTHERN NEVADA

Las Vegas Regional Office
1860 East Sahara Avenue
Las Vegas, NV 89104
Phone 702-486-3545
Fax 702-486-3569

Revised 5/11

COMMUNITY BASED Services (CBS)
SERVICE PROVIDER MANUAL ACKNOWLEDGEMENT

Please sign below indicating that you have received and read this Service Provider Manual and agree to abide by the guidelines described therein. This form must be returned with your provider application.

I have read and agree to the guidelines described in the Service Provider Manual.

Service Provider

_____

_____

_____

_____
Phone

_____
Fax

_____
(Authorized Signature)

_____
(Print Name)

_____
(Title)

_____
(Date)

AGING AND DISABILITY SERVICES DIVISION

Elder Rights Unit
Elder Protective Services Program
Service Provider Manual

State of Nevada – Department of Health and Human Services
Aging and Disability Services Division
3416 Goni Road, Suite D - 132
Carson City, Nevada 89706
Phone 775-687-4210; Fax 775-687-0574
adsd@adsd.nv.gov

Revised May 24, 2013

Table of Contents

ELDER PROTECTIVE SERVICES
SERVICE PROVIDER MANUAL

The billing procedures addressed in this manual refer to Mental Capacity Evaluations and Temporary Assistance for Displaced Seniors (TADS).

1.0 Service Authorization – Mental Capacity Evaluations

1.1 Social work supervisors will authorize all requests for Mental Capacity Evaluations. Aging and Disability Services Division (ADSD) will only reimburse providers for services authorized by supervisors.

1.2 When a social worker determines a client is in need of a Mental Capacity Evaluation to determine competency they will fill out an Authorization for Mental Capacity Evaluation form. This form will be reviewed and signed by their supervisor approving the need for a Mental Capacity Evaluation. The completed Authorization for Mental Capacity Evaluation form will be emailed or faxed to the provider. Evaluations cannot be initiated until this approval is received by the provider.

1.3 The service provider will be responsible for contacting the client and securing an appointment for the Mental Capacity Evaluation as soon as possible but no later than 10 business days from the referral.

1.4 The provider shall perform the Mental Capacity Evaluation at the client's residence, unless the client is able to meet at the provider's office for the evaluation.

1.5 The provider will submit to ADSD a full written report of the findings, conclusions and recommendations regarding the client's need for a guardianship within 7 – 10 working days of the evaluation.

1.6 The provider will complete the Certificate of Incapacity and Admonishment of Rights forms when guardianship is recommended and return these forms with their written evaluation to the social worker.

2.0 Service Authorization – TADS

2.1 Social work supervisors will authorize all requests for TADS placements. ADSD will only reimburse providers for services authorized by supervisors.

2.2 When a social worker determines a client is in need of TADS placement they will fill out a TADS Authorization form. This form will be reviewed and signed by their supervisor approving the need for emergency placement. The completed authorization form will be emailed or faxed to the provider. Placement cannot occur until this approval is received by the provider.

2.3 The service provider will be responsible for providing usual and customary services to displaced seniors in need of temporary assistance. Including, but not limited to, coordinating and arranging for all necessary admission protocols, medical screenings, transportation to medical appointments, and obtaining prescription medication.

2.4 Services are generally provided for no more than 30 days until alternate housing arrangements can be established or other arrangements have been made with the authorizing ADSD office.

3.0 Transportation

3.1 Providers are prohibited from transporting clients. ADSD will not reimburse any provider for transporting clients for any reason unless otherwise stated in the Provider Agreement.

4.0 Client Not at Home/Client Refuses Services

4.1 The provider is responsible for contacting clients prior to the in-home visit to ensure the client will be home. Providers will not be reimbursed for a visit where a client was not at home.

5.0 Billing Procedures

5.1 Provider Invoices

A. A Provider Invoice shall be completed for each client. (Refer to forms section for instructions on completing the Provider Invoice.) Exhibits A, B and C.

B. Providers may computerize the forms for their own convenience as long as the format remains intact.

C. Provider Invoices for TADS providers will only cover a one-month period, i.e., portions of previous or subsequent months are not to be included. For example, the bill for June is to cover June 1 through 30 only. Do not include any days for May or July.

D. Provider Invoices are to be mathematically correct and correspond to services delivered/authorized by ADSD and verified by ADSD client.

E. Provider Invoices that are not correct will be returned to the provider thereby delaying reimbursement.

F. The provider name and address shall be the same as listed on the provider agreement. ADSD shall be notified in writing of any changes. The provider is also responsible for establishing a vendor number as well as reporting any name and address changes or deletions to Vendor Services through the State Controller's Office (http://controller.nv.gov/).

5.2 Client Verification Log

A. Providers are responsible for obtaining client verification of the dates, units and types of service provided. Each document shall contain original signatures and be obtained on the date of service. Any billing not containing an original signature at the time of service will be rejected. See sample Client Verification Logs, Exhibits D and E and Client Verification Log Instructions, Exhibits D-1 and Exhibit E-1.

B. If a client has difficulty signing the Client Verification Log, the client may sign his/her initials only.

C. If a client is unable to sign the Client Verification Log, a designated representative for the client may sign the form. Use of a designated representative shall be approved by the social worker.

D. The social worker shall approve the use of an "X" if the client cannot sign his/her name or initials or there is no designated representative who can sign the Client Verification Log.

E. Providers shall notify the social worker if a client refuses to sign for services. The provider will document the refusal on the Client Verification Log and that the social worker has been notified.

F. The original Client Verification Log shall be attached to the original Provider Invoice for each client. Copies will not be accepted.

5.3 Travel Expenses

Reimbursement for mileage to and from the client's residence for Mental Capacity Evaluation providers only will be made by submitting a completed State of Nevada Travel Expense Reimbursement Claim form, Exhibit F. Travel expenses shall be included on the Provider Invoice, Exhibit A. Travel reimbursement for TADS providers is included in the provider rate.

A. All travel shall be by the least expensive method of travel.

B. When using a personal vehicle mileage will be reimbursed pursuant to policy; fuel will not be reimbursed.

C. For Mental Capacity Evaluation providers the original Travel Expense Reimbursement Claim form shall be attached to the original Provider Invoice and the expense shall be included on the Provider Invoice in order to be reimbursed for allowable travel expenses.

D. Travel expenses are defined as follows: Travel mileage will be reimbursed at the current state rate. Mileage calculation begins at the providers usual work location or wherever the provider is starting from, whichever is less. Meals will be reimbursed at the General Services Administration (GSA) rate if travel occurs beyond 50 miles of the providers normal work station and during meal hours. Meal hours are defined as leaving at or before 7:00 am for breakfast, leaving at or before 11:00 am and returning after 1:30 pm for lunch, and leaving at or before 5:30 PM and returning after 7:00 pm for dinner. GSA rates can be found at the following link: http://www.gsa.gov/portal/content/101518

5.4 Submission of Provider Invoices

A. The following documentation shall be included with all Provider Invoices:

A.1. The original Provider Invoice;

A.2. one copy of the Provider Invoice attached to the original;

A.3. the original Client Verification Log signed by the client and the provider;

A.4. and, for Mental Capacity Evaluation providers only, the original Travel Expense Reimbursement Claim form.

B. Provider Invoices are to be submitted by the 10th day of the month following service delivery.

C. Provider Invoices are to be submitted to the Elder Protective Services (EPS) administrative assistant in the Carson City office.

D. Reimbursement for Provider Invoices submitted later than the 10th day of the following month may be delayed.

6.0 Payment of Provider Invoices

6.1 The EPS administrative assistant will review Provider Invoices for accuracy and compliance as to type and amount of services authorized and verify original signed Client Verification Logs are received. Original Client Verification Logs along with a copy of the Provider Invoice will be retained by the EPS administrative assistant pursuant to the ADSD retention schedule.

6.2 Provider Invoices reviewed and approved by the EPS administrative assistant in the Carson City office, are then submitted to the ADSD fiscal unit for payment processing. Incorrect Provider Invoices will be returned to the provider per Section 8.0.

6.3 Upon fiscal unit approval via the State's Integrated Financial System (IFS), the State Controller will issue an Electronic Funds Transfer (EFT) or a check (on rare occasions). EFT notices, or checks, will be mailed by the State Treasurer's Office directly to the service provider. The payment process may take up to 4 weeks after ADSD has received a complete and correct Provider Invoice. The EFT/Check stub will identify the month and amount being paid. A copy of the Provider Invoice will be forwarded along with the payment notice.

7.0 Incorrect Provider Invoices

The EPS administrative assistant in Carson City will return incorrect Provider Invoices and accompanying documentation to service providers within 5 working days of receipt. A revised Provider Invoice and accompanying documentation shall be returned to the local ADSD office within 5 working days. ADSD staff is not permitted to make corrections to Provider Invoices, all corrections shall be made by the provider.

8.0 Stale-Dated Provider Invoices

8.1 Provider Invoices that are submitted more than 45 days after services are provided are considered stale-dated claims.

8.2 ADSD will not reimburse providers for stale-dated claims unless documented good cause is shown why the Provider Invoice was not submitted in a timely manner. An example of good cause would be an event or disaster that disrupts normal services.

9.0 Adjustments to Provider Invoices

Occasionally, an overpayment or underpayment may be made. When this occurs, a letter will be sent to the service provider explaining what has occurred and what steps will be taken to make the corrections.

10.0 Questions on Payment

Questions on payment of submitted Provider Invoices should be directed to the Elder Rights Administrative Assistant in the Carson City office at 775-687-4210.

11.0 Charges to the Client

The service provider shall not bill any EPS client directly for services delivered that were authorized under the EPS program. Donations may not be solicited nor additional fees levied against the client for services reimbursed by EPS. Providers should not discuss payment or charges with the client.

12.0 Tips/Gifts

Providers shall not accept tips or gifts from clients.

13.0 Record Retention

ADSD Elder Rights Unit requires providers to retain a client's records for three (3) years for Mental Capacity Evaluations and TADS.

13.1 Each provider agency shall have a file for each client. In the client's file, the agency shall document the actual time spent providing services and the services provided. Periodically, ADSD staff may request this documentation to compare it to billings submitted. These records shall be maintained by the provider for at least three years after the date the claim is paid.

14.0 Billing Address

Aging and Disability Services Division, Elder Rights Unit
3416 Goni Road Ste D-132
Carson City, Nevada 89706
Phone: 775-687-4210
Fax: 775-687-0574

EXHIBIT A
Sample Mental Capacity Evaluations Invoice

AGING AND DISABILITY SERVICES DIVISION
ELDER PROTECTIVE SERVICES
PROVIDER INVOICE

Dr. Bob Thomas
PROVIDER NAME

123 Main Street Carson City, NV 89701
PROVIDER ADDRESS

775-555-1212
PROVIDER PHONE

John Smith
CLIENT NAME

456 First Street Carson City NV 89701
CLIENT ADDRESS

January 3 2013
BILLING FOR MO/DAY THRU MO/DAY YEAR

TYPE OF SERVICE	DATES OF SERVICE	TOTAL UNITS	RATE	TOTAL
Capacity Evaluation	January 3, 2013	1	$400.00	$400.00
Travel	January 3, 2013	See attached		$14.13
			TOTAL BILLED	$414.13

I HEREBY CERTIFY THIS BILL CORRECTLY REFLECTS ACTUAL SERVICES DELIVERED AS AUTHORIZED BY ADSD.

By Dr. Bob Thomas Date 1/25/2013
Authorized Signature

FOR EPS UNIT USE ONLY

DO RECEIPT _____ _____
DATE INITIALS

CO RECEIPT _____ _____ PAID _____ _____
DATE INITIALS DATE VOUCHER

EXHIBIT B
Sample TADS Invoice

AGING AND DISABILITY SERVICES DIVISION
ELDER PROTECTIVE SERVICES
PROVIDER INVOICE

A Group Home
PROVIDER NAME

123 Main Street Carson City, NV 89701
PROVIDER ADDRESS

775-555-1212
PROVIDER PHONE

John Smith
CLIENT NAME

456 First Street Carson City NV 89701
CLIENT ADDRESS

January 3 – January 18 2013
BILLING FOR MO/DAY THRU MO/DAY YEAR

TYPE OF SERVICE	DATES OF SERVICE	TOTAL UNITS	RATE	TOTAL
TADS	January 3 – January 18, 2013	15 days	$100.00	$1,500.00
			TOTAL BILLED	$1,500.00

I HEREBY CERTIFY THIS BILL CORRECTLY REFLECTS ACTUAL SERVICES DELIVERED AS AUTHORIZED BY ADSD.

By *Jane Doe* Date 1/25/2013
Authorized Signature

FOR EPS UNIT USE ONLY

DO RECEIPT _____ _____
DATE INITIALS

CO RECEIPT _____ _____ PAID _____ _____
DATE INITIALS DATE VOUCHER

EXHIBIT C

AGING AND DISABILITY SERVICES DIVISION
ELDER PROTECTIVE SERVICES
PROVIDER INVOICE INSTRUCTIONS

The Provide Invoice is to be used to bill ADSD for authorized services. One Provider Invoice is to be completed for each client. TADS providers shall submit a Provider Invoice for each month services are delivered. (i.e. Client is in TADS placement July 20 through August 10, two Provider Invoices would be completed, one for July 20 through July 31 and one for August 1 through August 10.) The Provider Invoice shall be legible and completed in its entirety.

PROVDER NAME: Self Explanatory

PROVIDER ADDRESS: Enter provider address for reimbursement.

PROVIDER PHONE: Self Explanatory

CLIENT NAME: Self Explanatory

CLIENT ADDRESS: Self Explanatory

BILLING FOR MO/DAY THRU MO/DAY YEAR:

Enter the month and day the billing begins and ends and the year.

TYPE OF SERVICE: Enter type of service provided (i.e. Mental Capacity Evaluation or TADS). Codes or abbreviations are not acceptable.

DATES OF SERVICE: Enter the date(s) services were provided. Date ranges are acceptable for TADS providers if service was provided on all days within the range.

TOTAL UNITS: Enter the total number of units provided. Mental Capacity Evaluations: 1 evaluation = 1 unit. TADS: 1 day = 1 unit.

RATE: Enter total cost for 1 unit of service.

TOTAL: Enter the amount of total units multiplied by the rate.

TOTAL BILLED: Enter the total amount billed by the provider.

AUTHORIZED SIGNATURE:

The Provider Invoice is to be signed and dated by the individual responsible for billing.

DATE: Self Explanatory

EXHIBIT D
Sample Client Verification Log – Mental Capacity Evaluations

AGING AND DISABILITY SERVICES DIVISION
ELDER PROTECTIVE SERVICES
CLIENT VERIFICATION LOG
MENTAL CAPACITY EVALUATION

Last Name Smith First Name John M.I. _____

Billing Date 1/25/2013

DAY	DATE	FROM:	TO:	PROVIDER SIGNATURE	CLIENT SIGNATURE
SUN					
MON					
TUE					
WED					
THU	1/3/2013	8:30 AM	12:45 PM	Dr. Jane Thomas	John Smith
FRI					
SAT					

EXHIBIT D-1

AGING AND DISABILITY SERVICES DIVISION
ELDER PROTECTIVE SERVICES
MENTAL CAPACITY EVALUATION
CLIENT VERIFICATION LOG INSTRUCTIONS

LAST:	Enter last name of client.
FIRST:	Enter first name of client.
M.I.:	Enter middle initial of client.
BILLING DATE:	Enter date evaluation conducted.
DATES:	Enter date of service.
FROM COLUMN:	Enter time service begins.
TO COLUMN:	Enter time service ends.
PROVIDER SIGNATURE:	Self Explanatory.
CLIENT SIGNATURE:	Obtain client signature verifying date and time of service. Initials are acceptable if client has difficulty signing due to physical limitations. The authorizing social worker shall approve the use of an "X" or signature stamp.

EXHIBIT E
Sample Client Verification Log – TADS

AGING AND DISABILITY SERVICES DIVISION
ELDER PROTECTIVE SERVICES
CLIENT VERIFICATION LOG
TADS

Last Name Smith First Name John M.I. _____

Billing Date 1/25/2013

DATE:	PROVIDER SIGNATURE	CLIENT SIGNATURE
1/8/13	Jane Doe	John Smith
1/9/13	Jane Doe	John Smith
1/10/13	Jane Doe	John Smith
1/11/13	Jane Doe	John Smith
1/12/13	Jane Doe	John Smith
1/13/13	Jane Doe	John Smith
1/14/13	Jane Doe	John Smith
1/15/13	Jane Doe	John Smith
1/16/13	Jane Doe	John Smith
1/17/13	Jane Doe	John Smith
1/18/13	Jane Doe	John Smith

EXHIBIT E-1

AGING AND DISABILITY SERVICES DIVISION
ELDER PROTECTIVE SERVICES
TADS
CLIENT VERIFICATION LOG INSTRUCTIONS

LAST:	Enter last name of client.
FIRST:	Enter first name of client.
M.I.:	Enter middle initial of client.
BILLING DATE:	Enter date billing is submitted.
DATE:	Enter each date the client is at the facility in a TADS placement.
PROVIDER SIGNATURE:	Self Explanatory.
CLIENT SIGNATURE:	Obtain client signature verifying date of service. Initials are acceptable if client has difficulty signing due to physical limitations. The authorizing social worker shall approve the use of an "X" or signature stamp.

EXHIBIT F
Sample Travel Expense Reimbursement Claim

State of Nevada

TRAVEL EXPENSE REIMBURSEMENT CLAIM

(SEE STATE ADMINISTRATIVE MANUAL 0200 FOR TRAVEL REGULATIONS)

Name: Dr. Bob Thomas

Employee ID#/ Bud. Acct: Vendor Number

Department/ Division/ Unit: Elder Rights Unit

Official Station: City where provider is located

I declare under penalties of perjury that to the best of my knowledge this is a true and correct claim in conformance with the governing statutes and the State Administrative Manual and its updates.

x I do not have a travel advance

____ I do have a travel advance from my agency or State Treasurer

Dr. Bob Thomas

Signature of Traveler

Agency Approval

Transportation Codes: *

P - Plane; PP - Private Plane; PC - Private Car; OT - Other: Limousine, Taxi, Shuttle, Rental Car, Inter-City Bus, Railroad

X - Passenger in Car; GS - Gasoline Reimbursement; SC - State Car: Motor Pool or Agency Car

Miscellaneous Codes:

A - ATM Fees*; I - Incidental Expense

Traveler is:

____ State Officer or Employee

____ Board or Commission Member

x Independent Contractor Whose Contract Provides for Travel

Date	Destination and Purpose of Each Trip	Travel Time Started	Travel Time Ended	Transportation Code	Transportation PC Mileage	Transportation Cost	Miscellaneous Expenses Code	Miscellaneous Expenses Cost	Daily Expenses Meals B	Meals L	Meals D	Lodging*	Total For Day
1/3/2013	John Smith Evaluation - Carson City	8:30 AM	12:45 PM	PC	25	14.13							14.13
Total of this Claim													14.13
Less Travel Advance Received from the Traveler's Agency or State Treasurer:													
Balance Due to Traveler:													14.13

***Receipts are required for:**
All Transportation Expenses, ATM, bank transactions, and Hotel expenses for Reimbursement

Traveler is personally liable for repaying advances and Travel Card charges.

This form is used for the State to reimburse the traveler and must be submitted within one month of completion of travel unless prohibited by exceptional circumstances (GSA and SAM 0220.0).

In accordance with GSA and the State Administrative Manual (SAM), travel claims, travel advances, reimbursement requests, etc. need employee and supervisor original

Form: TE
Revised: July 2011

15.0 Elder Protective Services (EPS) Service Provider Manual Acknowledgement

Please sign below indicating that you have received and read this Service Provider Manual and agree to abide by the guidelines described therein. This form shall be returned with your provider application.

I have read and agree to the guidelines described in the Service Provider Manual.

Service Provider

_____

_____

_____

_____
Phone

_____
Fax

_____
(Authorized Signature)

_____
(Print Name)

_____
(Title)

_____
(Date)

16.0 ADDENDUM – Printable Forms

AGING AND DISABILITY SERVICES DIVISION
ELDER PROTECTIVE SERVICES
PROVIDER INVOICE

PROVIDER NAME

PROVIDER ADDRESS

PROVIDER PHONE

CLIENT NAME

CLIENT ADDRESS

BILLING FOR MO/DAY THRU MO/DAY YEAR

TYPE OF SERVICE	DATES OF SERVICE	TOTAL UNITS	RATE	TOTAL
			TOTAL BILLED	

I HEREBY CERTIFY THIS BILL CORRECTLY REFLECTS ACTUAL SERVICES DELIVERED AS AUTHORIZED BY ADSD.

By_____ Date _____
Authorized Signature

FOR EPS UNIT USE ONLY

DO RECEIPT_____ _____
DATE INITIALS

CO RECEIPT_____ _____ PAID_____
DATE INITIALS DATE VOUCHER

AGING AND DISABILITY SERVICES DIVISION
ELDER PROTECTIVE SERVICES
CLIENT VERIFICATION LOG
MENTAL CAPACITY EVALUATION

Last Name _____ First Name _____ M.I. _____

Billing Date _____

DAY	DATE	FROM:	TO:	PROVIDER SIGNATURE	CLIENT SIGNATURE
SUN					
MON					
TUE					
WED					
THU					
FRI					
SAT					

Revised May 29, 2013

AGING AND DISABILITY SERVICES DIVISION
ELDER PROTECTIVE SERVICES
CLIENT VERIFICATION LOG
TADS

Last Name _____ First Name _____ M.I. _____

Billing Date _____

DATE:	PROVIDER SIGNATURE	CLIENT SIGNATURE

State of Nevada

TRAVEL EXPENSE REIMBURSEMENT CLAIM

(SEE STATE ADMINISTRATIVE MANUAL 0200 FOR TRAVEL REGULATIONS)

Name: _____

Employee ID#/ Bud. Acct: _____

Department/ Division/ Unit: Elder Rights Unit

Official Station _____

I declare under penalties of perjury that to the best of my knowledge this is a true and correct claim in conformance with the governing statutes and the State Administrative Manual and its updates.

x I do **not** have a travel advance

_____ I **do** have a travel advance from my agency or State Treasurer

_____
Signature of Traveler

_____
Agency Approval

Transportation Codes: *

P - Plane
PP - Private Plane
PC - Private Car
OT - Other: Limousine, Taxi, Shuttle, Rental Car, Inter-City Bus, Railroad
X - Passenger in Car
GS - Gasoline Reimbursement
SC - State Car: Motor Pool or Agency Car

Miscellaneous Codes:

A - ATM Fees*
I - Incidental Expense

Traveler is:

_____ State Officer or Employee
_____ Board or Commission Member
x Independent Contractor Whose Contract Provides for Travel

Date	Destination and Purpose of Each Trip	Travel Time		Transportation			Miscellaneous Expenses		Daily Expenses				Total For Day
		Started	Ended	Code	PC Mileage	Cost	Code	Cost	Meals B	Meals L	Meals D	Lodging*	
Total of this Claim													
Less Travel Advance Received from the Traveler's Agency or State Treasurer:													
Balance Due to Traveler:													

***Receipts are required for:**
All Transportation Expenses, ATM, bank transactions, and Hotel expenses for Reimbursement

Traveler is personally liable for repaying advances and Travel Card charges.

This form is used for the State to reimburse the traveler and must be submitted within one month of completion of travel unless prohibited by exceptional circumstances (GSA and SAM 0220.0).

Form: TE
Revised: July 2011

In accordance with GSA and the State Administrative Manual (SAM), travel claims, travel advances, reimbursement requests, etc. need employee and supervisor original

STATE OF NEVADA
VENDOR REGISTRATION

Mail or fax to:
STATE CONTROLLER'S OFFICE
555 E WASHINGTON AVE STE 4300
LAS VEGAS NV 89101-1071
PHONE: 702/486-3810 & 702/486-3856
FAX: 702/486-3813

All sections are mandatory and require completion. IRS Form W-9 will not be accepted in lieu of this form.

1. NAME For proprietorship, provide proprietor's name in first box and DBA in second box.

Legal Business Name, Proprietor's Name or Individual's Name	Doing Business As (DBA)

2. ADDRESS/CONTACT INFORMATION

Address A – Physical address of ☐ Company Headquarters ☐ Individual's Residence Is this a US Post Office deliverable address? ☐ Yes ☐ No			Address B ☐ Additional Remittance – PO Box, Lockbox or another physical location.		
Address			Address		
Address			Address		
City	State	Zip Code	City	State	Zip Code
E-mail Address			E-mail Address		
Phone Number	Fax Number		Phone Number	Fax Number	
Primary Contact			Primary Contact		

3. ORGANIZATION TYPE AND TAX IDENTIFICATION NUMBER (TIN) Check only **one** organization type and supply the applicable Social Security Number (SSN) or Employee Identification Number (EIN). **For proprietorship, provide SSN or EIN, not both.**

☐ Individual **(SSN)** ☐ Sole Proprietorship **(SSN or EIN)** ☐ Partnership **(EIN)** ☐ Corporation **(EIN)** ☐ Government **(EIN)** ☐ Tax Exempt/Nonprofit **(EIN)** ☐ Trust/estate **(SSN or EIN)**	**LLC** tax classification: ☐ Disregarded Entity ☐ Partnership ☐ Corporation /S Corp	**SSN** Name associated with SSN: **EIN** New TIN? ☐ No ☐ Yes – Provide previous TIN & effective date. Previous TIN: Date:

OTHER INFORMATION Check **all** that apply.

☐ Doctor or Medical Facility ☐ Attorney or Legal Facility	☐ In-State (Nevada) ☐ DBE Certificate #:	☐ NV Business ID # (ex:NV12345678910)

4. ELECTRONIC FUNDS TRANSFER ***Per NRS 227, payment to all payees of the State of Nevada will be electronic.***
Complete section **AND** provide a copy of a voided imprinted check for the account. If there are no checks for the account, savings or prepaid card, a signed letter restating the information must be provided (Companies must use company letterhead). **Deposit slip or Wire information will not be accepted.** Information on this form and the supporting documentation **must** match. Allow 10 working days for activation.

The information is for address ☐ A ☐ B ☐ Both		
Bank Name	Bank Account Type ☐ Checking ☐ Savings	Provide **ONE** e-mail address for receiving payment notification.
Transit Routing Number	Bank Account Number	

5. IRS FORM W-9 CERTIFICATION AND SIGNATURE

Under penalties of perjury, I certify that:
1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. citizen or other U.S. person (as defined by IRS Form W-9 rev August 2013).

Cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signature	Print Name & Title of Person Signing Form	Date

FOR STATE CONTROLLER'S OFFICE USE ONLY		**Name of State agency contact & phone number:**
Primary 1099 Vendor ☐	1099 Indicator ☐ Yes ☐ No	
Entered By	Date	Comments

Registration Instructions

General Instructions:

1. **This Registration form is for the use of United States entities only. Non-US entities must submit a Foreign Vendor Registration & IRS Form W-8.**
2. Type or **legibly** print all information except for signature.
3. All sections are mandatory and require completion.

Specific Information:

1. **NAME**
   a. Partnership, Corporation, Government or Nonprofit – Enter legal business name as registered with the Internal Revenue Service (IRS) in first box. If the company operates under another name, provide it in the second box.
   b. Proprietorship – Enter the proprietor's name in the first box and the business name (DBA) in the second box.
   c. Individual – Name must be as registered with the Social Security Administration (SSA) for the Social Security number (SSN) listed in Section 3.
2. **ADDRESS/CONTACT INFORMATION**
   a. Address A – *If the address is non-deliverable by the United States Postal Service, complete both Address A and B sections.*
   Company – Provide physical location of company headquarters.
   Individual – Provide physical location of residence.
   E-mail – Provide a valid e-mail address.
   Telephone Number – Include area code.
   Fax Number – Include area code.
   Primary Contact – Person (and phone number or extension) to be contacted for payment-related questions or issues.
   b. Address B – Provide additional remittance address and related information when appropriate.
3. **ORGANIZATION TYPE AND TAX IDENTIFICATION NUMBER (TIN OR EIN)**
   a. Individual – A person that has no association with a business.
   b. Proprietorship – A business owned by one person.
   c. Partnership – A business with more than one owner and not a corporation.
   d. Corporation – A business that may have many owners with each owner liable only for the amount of his investment in the business.
   e. LLC – Limited Liability Company. ***Must mark appropriate classification – disregarded entity, partnership or corporation.***
   f. Government – The federal government, a state or local government, or instrumentality, agency, or subdivision thereof.
   g. Tax Exempt/Nonprofit – Organization exempt from federal income tax under section 501(a) or 501(c)(3) of the Internal Revenue Code.
   h. Doctor or Medical Facility – Person or facility related to practice of medicine.
   i. Attorney or Legal Facility – Person or facility related to practice of law.
   j. In-state – Nevada entity.
   k. Disadvantaged Business Enterprise (DBE) – A small business enterprise that is at least 51% owned and controlled by one or more socially and economically disadvantaged individuals. ***Provide certification number.*** See http://www.nevadadbe.com for certification information.
   l. NV Business ID number issued by NV Secretary of State (ex: NV20110123456).
   m. The Taxpayer Identification Number (TIN) is always a 9-digit number. It will be a Social Security Number (SSN) assigned to an individual by the SSA or an Employer Identification Number (EIN) assigned to a business or other entity by the IRS. ***Per the IRS, use the owner's social security number for a proprietorship.***
4. **ELECTRONIC FUNDS TRANSFER**
   Per NRS 227, payment to all payees of the State of Nevada will be electronic. Provide a copy of a voided imprinted check or restate bank information on signed letterhead. ***Deposit slip or wire information will not be accepted.*** All information on this form and the supporting documentation **must match**.
   a. Bank Name – The name of the bank where account is held.
   b. Bank Account Type – Indicate whether the account is checking or savings.
   c. Transit Routing Number – Enter the 9-digit Transit Routing Number for automatic/direct deposit or ACH.
   d. Bank Account Number – Enter bank account number including 0's if any.
   e. Direct Deposit Remittance Advice – payment information is sent via e-mail. Companies should provide an e-mail address that will not change. Example: accounting@business.com.
5. **IRS FORM W-9 CERTIFICATION AND SIGNATURE**
   a. The Certification is copied from IRS Form W-9 (rev. August 2013). See IRS Form W-9 for further information.
   b. The Signature should be provided by the individual, owner, officer, legal representative or other authorized person of the entity listed on the form.
   c. Print the name and title, when applicable, of the person signing the form.
   d. Enter the date the form was signed. Forms over 60 days old will not be processed.

Do not complete any remaining areas. They are for State of Nevada use only.

Mail or Fax signed form to:

NEVADA STATE CONTROLLER'S OFFICE
555 E WASHINGTON AVE STE 4300
LAS VEGAS NV 89101-1071
Fax: 702/486-3813

For questions contact 702/486-3810 or 702/486-3856 or vendordesk@controller.state.nv.us ***(DO NOT EMAIL FORMS)***

This form is to be used if the awarded vendor is a sole proprietor and rejects the State's requirement of Workers Compensation.

Contact Risk Management for assistance at (775) 687-3188.

DEPARTMENT OF ADMINISTRATION

RISK MANAGEMENT

AFFIDAVIT OF REJECTION OF INDUSTRIAL INSURANCE COVERAGE

STATE OF _____)
) ss.
_____COUNTY)

I, _____, being first duly sworn, depose and state as follows under penalty of perjury, and by my initials on each paragraph, I certify that I have read and understand each paragraph.

1. I make this affidavit for the purpose of rejecting industrial insurance coverage, pursuant to NRS 616B.627 and NRS 617.210, in connection with entering into a Contract with the State of Nevada or political subdivision of the State of Nevada. After reviewing those statutes and the definitions of "sole proprietor" in NRS 616A.310 and NRS 617.145, I believe I qualify to reject industrial insurance coverage, and I covenant that I will not knowingly do anything that would disqualify me from rejecting industrial insurance under those statutes, without first withdrawing this Affidavit of Rejection and obtaining all statutorily required industrial insurance coverage. ____

2. I am a sole proprietor, as defined by NRS 616A.310 and NRS 617.145, who will not use the services of any employees, subcontractors, or independent contractors in the performance of this Contract with the State of Nevada. _____

3. In accordance with the provisions of NRS 616B.659, I have elected to reject the industrial insurance terms, conditions, and provisions of NRS Chapters 616A to 616D inclusive. By doing so I acknowledge that if I incur an industrial injury or occupational disease in the performance of this Contract that I waive and will be disqualified to receive any workers' compensation coverage pursuant to Nevada law or the laws of any other state where I have waived coverage. _____

4. In accordance with the provisions of NRS 617.225, I have elected to reject the workers' compensation terms, conditions, and the provisions of NRS Chapter 617 as it relates to occupational diseases. By doing so, I acknowledge that if I incur an industrial injury or occupational disease in the performance of this Contract that I waive and will be disqualified to receive any workers' compensation or occupational disease benefits pursuant to Nevada law or the laws of any other state where I have waived coverage.

_____

5. I acknowledge that the State of Nevada will not be considered to be my employer or the employer of my employees, subcontractors or independent contractors, if any; and that the State of Nevada is not liable as a principal contractor to me or my employees, subcontractors or independent contractors for any compensation or other damages as a result of an industrial injury or occupational disease incurred

in the performance of this Contract. _____

6. I acknowledge that by signing this waiver I am not eligible for any workers' compensation or occupational disease benefits that I may be otherwise eligible, in the performance of this Contract. I acknowledge that should I incur any industrial injury or occupational disease in the performance of this Contract that I will be responsible for any costs, including medical, disability and rehabilitation benefits that I may incur. _____

7. Prior to executing this affidavit, I have had a full and fair opportunity to answer any questions I may have had regarding industrial insurance or occupational disease benefits and liabilities under Nevada law, including the opportunity to consult with counsel of my choice, and this Waiver is made with full knowledge of any liabilities that may incur. _____

8. I have read the provisions of NRS Chapters 616A to 616D, inclusive, and NRS Chapter 617 and I am otherwise in compliance with the terms, conditions and provisions thereof._____

9. I, _____, do hereby swear under penalty of perjury that the assertions of this affidavit are true. _____

_____
NAME

SUBSCRIBED and SWORN to before me

by_____

this ____ day of _____ 20____.

_____
Notary Public, in and for said
County and State